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

This policy was issued in consideration of the Policyholder's signed Group Insurance Plan Application and the payment of the first monthly premium.

POLICY NUMBER	:	**66719**
PLAN MAJOR GROUP NUMBER	:	**55823**
POLICYHOLDER	:	**Heritage College Student Association (HCSA)**
SUBSIDIARY, AFFILIATED COMPANY OR BRANCH OFOTHER AFFILIATES OF POLICYHOLDER	:	
BENEFITS	:	**Critical Illness Insurance** **Health Insurance** **Dental Insurance**
EFFECTIVE DATE OF THE POLICY	:	**January 1, 2019**
EFFECTIVE DATE OF THIS CONTRACT	:	**August 15, 2026**
NEXT RENEWAL	:	**August 15, 2027**

This contract, which covers the period from August 15, 2026 to August 14, 2027 is issued at Moncton, New Brunswick on

Sébastien Dupuis
President and Chief Executive Officer

August 20, 2026
Date

Table of Contents

GENERAL PROVISIONS

1. Definitions A–1
2. Terms of the Contract A–3
3. Changes to the Contract A–3
4. Eligibility A–3
5. Application for Group Insurance A–4
6. Effective Date of Insurance A–4
7. Student's Rights on Effective Date of Benefits A–4
8. Termination of Insurance A–5
9. Termination of the Contract A–5
10. Premiums A–6
11. Grace Period A–6
12. Renewal A–6
13. Certificate A–6
14. Policyholder Administration A–7
15. Limitation of Actions A-7
16. Waiver A–7
17. Incontestability A–8
18. Collection A–8
19. Medical Requirements A–8
20. Assignment or Pledge A–8
21. Currency A–8
22. Subrogation and Reimbursement – Third-Party Liability A–8
23. General Provisions A–9

CRITICAL ILLNESS INSURANCE

1. Scope and Benefit F–1
2. Eligible Critical Illnesses F–1
3. Additional Definitions F–7
4. Cancer and Benign Brain Tumor Moratorium Exclusion F–8
5. Increase in Benefit Coverage F–8
6. Student's Duty to Disclose Cancer F–8
7. Other Exclusions F–9
8. Survival Period F–9
9. Termination F–10
10. Beneficiary F–10
11. Notice and Proof of Claim F–10
12. Autopsy F–10
13. Payment of Benefits F–10
14. Appealing a Decision F–10
15. Income Tax Status F–11

HEALTH INSURANCE

1. Scope I–1
2. Definitions I–1
3. Conditions and Eligibility I–4
4. Eligible Expenses I–4
5. Coordination of Benefits I–6
6. Termination, Limitations and Exclusions I–8
7. Terms for Applying the Deductible I–9
8. Notice and Proof of Claim I–10
9. Survivor Benefits I–10

DENTAL INSURANCE

1. Scope K–1
2. Definitions K–1
3. Eligible Expenses K–2
4. Coordination of Benefits K–5
5. Termination, Limitations and Exclusions K–6
6. Terms for Applying the Deductible K–7
7. Preliminary Assessment K–7
8. Notice and Proof of Claim K–8
9. Survivor Benefits K–8

BENEFIT SCHEDULE

CLASS

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.

1. CRITICAL ILLNESS INSURANCE

CRITICAL ILLNESS FOR STUDENT

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

Coverage will terminate at the earliest of the following:

(a) The date on which the Student reaches 65 years of age.
(b) The date on which the Student is no longer eligible for this coverage.
(c) The date on which this policy terminates.

2. HEALTH CARE INSURANCE

Hospitalization

Coinsurance: 100 %

Expenses for a semi-private Hospital room
Direct payment to Hospital
$30 per day (maximum 5 consecutive days) up to a maximum of $400 per Insured Person per Coverage Period

Extended Health Benefits

Coinsurance: 70 %
Reimbursement for eligible expenses

- The professional services of a registered private nurse up to a maximum of $500 per Insured Person per Coverage Period.

Coinsurance: 60 %
Reimbursement for eligible expenses

- Ambulance transportation up to a maximum of $350 per Insured Person per Coverage Period. Fees for ambulance transportation by ground or air in the case of a medical Emergency to the closest Hospital.

Coinsurance: 70 %
Reimbursement for eligible expenses

- Non-medical access-related expenses for a voluntary termination of pregnancy (abortion), up to a maximum of $400 per insured person per coverage period. **Medical recommendation required**.

Coinsurance: 60 %
Reimbursement for eligible expenses

- Hair prostheses (required due to a pathological condition or following chemotherapy treatment) up to a lifetime maximum per Insured Person of $350*.
- External breast prostheses following a mastectomy, up to $200* per Insured Person per Coverage Period.
- Laboratory tests, X-rays and ultrasounds, up to a maximum of $200* per Insured Person per Coverage Period. Ultrasounds for maternity are covered. **Medical recommendation required**.
- Blood tests and analysis for diagnostic purposes, up to a maximum of $100*.
- Purchase of compression garments for burns up to a maximum of $350* per Insured Person per Coverage Period.

* **Expenses for hair prostheses, breast prostheses, Laboratory tests, X-rays and ultrasounds, blood tests and analysis, and compression garments are subject to a combined maximum of $350 per Insured Person per Coverage Period.**

Drugs Expenses

Coinsurance: 70 %
Reimbursement for eligible expenses

Drugs listed by RAMQ – Basic plan: Not covered

Additional items covered:

- **Antidepressants** registered and non-registered on the RAMQ list (Assumption Life 2nd payor). **
- Oral **contraceptives**, IUDs with hormones, contraceptive injections, contraceptive rings, contraceptive patches, contraceptive implants, registered and non-registered on the RAMQ list (Assumption Life 2nd payor). **
- **Neurostimulants**, registered and non-registered on the RAMQ list (Assumption Life 2nd payor). **
- **Vaccines** not covered by RAMQ or any other provincial plan (excluding administration fees and allergy shots), up to a maximum of $100 per coverage period.
- **Post-exposure prophylaxis (PEP)** for the prevention of HIV infection, up to a maximum of $500 per insured person per coverage period. (Assumption Life 2nd payor).

** Mandatory generic substitution

Drug expenses, excluding post-exposure prophylaxis (PEP), are subject to a combined maximum of $400 per Insured Person per Coverage Period.

Paramedicals

Coinsurance: 100 %

Paramedical services provided by an acupuncturist, chiropractor, dietician/nutritionist, physiotherapist, massage therapist, podiatrist, up to a maximum of $40 per visit and a combined maximum of up to $400 per Insured Person per Coverage Period.

The expenses for paramedical x-rays, if applicable, are included in the paramedical services Maximum Amount.

Fees for psychometric testing performed by a licensed therapist are covered up to a maximum of $300 per period of 36 consecutive months.

Paramedical, including psychometric testing, and vision care, are subject to a combined maximum of $500 per Insured Person per Coverage Period.

Vision Care

Coinsurance	100%
Vision exam expenses per period of 12 consecutive months	$50
Expenses for eyeglasses or contact lenses per period of 24 consecutive month	$200

Paramedical, including psychometric testing, and vision care, are subject to a combined maximum of $500 per Insured Person per Coverage Period.

Coverage for the Student and, if applicable, for Dependents 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 Student is no longer eligible for this coverage.

(c) The date on which this policy terminates.

3. DENTAL CARE

Annual deductible:	
Individual	$0
Family	$0
Part I A – Diagnostic & prevention services	
- Diagnostic & prevention	80%
- Recall Exam	80%
Part I B – Basic dental care services Coinsurance	
- Minor Restoration	80%
- Oral Surgery	75%
- Endodontics	75%
- Periodontics	80%
Part II Major Restoration and Surgery	
- Crowns	N/A
Part III Prosthodontics	N/A
Part IV Orthodontics (for a Child under 21 years of age)	N/A
DENTAL ACCIDENT INSURANCE	N/A
Total expenses for dental accident insurance	N/A
Maximum benefit per Insured Person:	
Global maximum per coverage period	$500
Expenses for Part IV per lifetime	N/A

The applicable dental fee guide is the current guide used in the Student's province of residence. If there is no applicable guide, the New Brunswick guide is used.

Coverage for the Student and, if applicable, for Dependents 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 Student is no longer eligible for this coverage.

(c) The date on which this policy 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.

The **Policyholder** is the Association designated as such in the Group Insurance Plan Application. Along with the Insurer, the Policyholder is one of the two parties to this contract.

The **College** is the educational institution as indicated on the group insurance applicable.

The **Coverage Period** is the current academic year as indicated in the Summary of benefits.

The **Dependent** of a Student is their Spouse or Child.

1) The **Spouse**, meaning the only person of the opposite or same sex considered to be the Student's Spouse who:
   (a) by virtue of a marriage not dissolved by divorce, annulment or cessation of permanent cohabitation; or,
   (b) or by the fact of a civil union not dissolved by divorce, annulment or cessation of permanent cohabitation with the Student for more than one year; or,
   (c) by the fact that this person has resided permanently with the Student for more than one year, with the Student publicly presenting this person as his or her Spouse.

2) The **Child** is the biological Child, adopted Child or stepchild of the Insured Person or the Spouse (as defined in article 1)) or of both, who depends on the Student for support and who:
   (a) is older than 24 hours and under the age of 21;
   (b) is under the age of 21 and not working more than 20 hours per week, unless they are a full-time Student; or,
   (c) is older than 21and under the age of 26 provided they are a regular full-time day Student in a recognized academic institution; or
   (d) regardless of age, has a physical or mental disability resulting from an Accident or Illness that requires regular medical care. The disability must have begun prior to the Child being 24 hours old or while they were considered a Dependent as defined above and be of such nature that they are incapable of pursuing a gainful occupation.

A **Health Specialist** means a person who is licensed to practice medicine, who acts within the limits of licensure and who has completed graduate and clinical training in a specific field of medicine. Only a licensed Physician practicing in Canada falls within this definition. Excluded are the Insured Person, a person living with the Insured Person or their Spouse, the Child, parent, brother or sister of the Insured Person or their Spouse.

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 and 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 the admission to a Hospital as:

a) An inpatient 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 a 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 **Insured Person** is, as the case may be, a Student residing in Canada, eligible for insurance and insured under this contract, or one of their Dependent.

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

The **Modification and Withdrawal Period** is the period predetermined by the Policyholder and Plan Major during which the Insured Person may make changes to their plan or withdraw from it. The exact dates of this period are expressly communicated on the Plan Major website. Each Insured Person has one Modification or Withdrawal Period per Coverage Period during which they may exercise their right to withdraw.

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 **Plan Major Group Number** is the number used for claims processing in the administrative system designated by Plan Major. Should this reference number become null and void, this shall in no way constitute a waiver of any other clause or condition of this document.

The **Policy Number** is the number used by the Insurer to identify the Policy that was issued.

Pregnancy includes the gestation period, childbirth, abortion and miscarriage.

Student means the person who is a member of Heritage College Student Association.

Sound Mind means the state of mind of the Insured who is not prevented from forming intent due to the influence of narcotics, drugs, medication or alcohol, or of any psychological, nervous or medical disorder or state.

Usual, Customary and Reasonable Expense refers to the standard or most common charge or fee for a particular medical service when rendered in a particular geographic area. It is often employed in determining provincial healthcare payment amounts. Usual, Customary and Reasonable Expenses are split into three parts:

1) "usual charge or fees" are what the medical professional normally charges for a given procedure for treatment,

2) "customary charge or fees" are what the Insurer is willing to pay for a given procedure or treatment, and
3) "reasonable charge or fees" are fees the medical professional may charge when a procedure or treatment has complications or unusual circumstances.

A **Vehicle** (motorized) is a propulsion engine that is intended to transport or handle people, objects or goods. A Vehicle can be, but is not limited to, among other things, an automobile, a moped, a boat, a watercraft, a snowmobile, a tractor, an aircraft or a recreational Vehicle.

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 applications 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 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 equivalent of any other medical insurance program of another province.

The above notwithstanding, any **Student** who is not a citizen or Canadian resident can only benefit from the protecting 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 the comply with the definition of a Dependent under this contract.

5. APPLICATION FOR GROUP INSURANCE

(c) Student

Enrollment is automatic for all eligible Students, with possibility of withdrawal during the Modification and Withdrawal Period. Each Student has one Modification and Withdrawal Period per semester during which they can withdraw from the plan.

(d) Dependents

If a Student wishes to insure their Dependents under this contract, they must complete and submit an application to Plan Major during the Modification and Withdrawal Period.

If the Dependent is older than the age specified in the definition of Child and is a full-time Student at a recognized educational institution, supporting documents to this effect must be sent to the Insurer annually or at any other frequency required by the Insurer.

For a Dependent who, regardless of age, has a physical or mental disability resulting from an Accident or Illness requiring regular medical care, the Student must provide supporting documentation deemed sufficient by the Insurer.

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) They are actively studying;
(b) They are insured by the province's health insurance plan, or an equivalent private insurance plan;
(c) They have not withdrawn during the Modification and Withdrawal Period.
(d) Their tuition fees have been paid in full. Any claim made after the beginning of the current session but before the payment in full or the tuition fees will be eligible for reimbursement following the payment of said tuition, provided that they 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, Students 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 Student belongs 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 Student and, as the case may be, that of their 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 Student makes false representations to the Insurer or the date that they commit a fraudulent act that affects the Insurer.

(e) The day that the Student no longer meets the eligibility criteria in 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 issued at least 31 days prior to the date of anniversary of the Period of Coverage, which is every 12 months from the effective date of this Policy;

(d) Upon written notice from the Insurer to the Policyholder, on 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 their obligations under the contract;

(e) 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 in at least 31 days prior to this date; or,

(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 Policyholder is responsible for collecting the premiums from each Student. Premiums are payable in advance by the Policyholder to the Insurer.

11. GRACE PERIOD

For the payment of each premium, the Policyholder must remit the premium to the Third Party Administrator or the Insurer within 30 days 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

Plan Major must provide the Policyholder with certificates of insurance. The Policyholder must distribute these certificates to the Students.

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 Student and the beneficiary are entitled to consult, at the Policyholder's place of business, the Policy and to make a copy thereof.

The Policyholder shall diligently provide the Insurer with any information necessary for administering this Policy. The Policyholder authorizes the Insurer to examine their records and files at any reasonable time while this contract is in force and for a period of two years following its termination.

Ontario Residents only:

- If a Student made a beneficiary designation for benefits provided by the previous benefits carrier,this designation is automatically transferred under this contract, unless the Student changes this designation by submitting a Beneficiary Designation form to their benefits administrator.

15. LIMITATION OF ACTIONS

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

16. WAIVER

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

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

17. INCONTESTABILITY

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

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

18. COLLECTION

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

19. MEDICAL REQUIREMENTS

The Insurer reserves the right, at any time and at its sole discretion, to have any Insured Person provide one or more specific medical certificates.

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

20. ASSIGNMENT OR PLEDGE

Insurance under this contract may not be assigned or pledged.

21. CURRENCY

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

22. SUBROGATION AND REIMBURSEMENT – THIRD-PARTY LIABILITY

(a) Health and Dental Insurance Coverage

When any amount is paid out to a person under the health or dental insurance coverage provided by this Policy due to an event 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 Student's several liability or contributory negligence shall not affect the obligations of the Student or the rights of the Insurer under this section.

23. GENERAL PROVISIONS

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

CRITICAL ILLNESS INSURANCE

1. SCOPE AND BENEFIT

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

For the claim to be payable to the Student, it must be submitted and approved during the Student's lifetime. If the claim is approved following the Student's death, the claim will be payable to the Student's estate.

2. ELIGIBLE CRITICAL ILLNESSES

The following are defined as Critical Illnesses for the purposes of this section:

Aortic Surgery

Description: **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

Description: **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

Description: **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

Description: **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.

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 and the date of last reinstatement of the policy, where applicable, the Student 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 the Insurer within six months of the date of the Diagnosis. If this information is not provided within this period, the Insurer reserves 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

Description: **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

Description: **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.

Exclusion: 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

Description: **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

Description: **Coronary Artery Bypass Surgery** means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s).

Exclusion: any non-surgical or trans- catheter techniques such as balloon angioplasty or laser relief of an obstruction.

Deafness

Description: **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

Description: **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.

Requirements: The Student 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 Health Specialist.

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

Heart Attack

Description: **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

Description: **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 Health 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 nonsurgical procedure.

Kidney failure

Description: **Kidney failure** means a definite Diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular hemodialysis, peritoneal dialysis or renal transplantation s initiated.

Loss of Independent Existence

Description: **Loss of Independent Existence** is defined as a definite Diagnosis of the total inability to perform, by oneself, at least two of the following six Activities of Daily Living for a continuous period of at least 90 days with no reasonable chance of recovery.

Requirements: 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

Description: **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

Description: **Loss of Speech** is defined as a formal Diagnosis of total and irreversible loss of the ability to speak following an Illness for a period of at least 180 days.

Major Organ Failure on Waiting List for Transplant

Description: **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.

Requirements: To qualify under Major Organ Failure on Waiting List for Transplant, the Student must become enrolled as the recipient in a recognized transplant center 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 Student's enrolment with the transplant center.

Major Organ Transplant

Description: **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.

Requirements: To qualify under Major Organ Transplant, the Student must undergo a transplantation procedure as the recipient of a heart, lung liver, kidney or bone marrow.

Motor Neurone disease

Description: **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

Description: **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

Description: **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 Student'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 Critical Illness 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 Health Specialist.

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

1) The Student 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

Definition: **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

Definition: **Parkinson's disease** means a definite Diagnosis of primary idiopathic Parkinson's disease, which ischaracterized 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).

Requirements: To qualify under Parkinson's Diseases the Student must require substantial physical assistance from another adult to perform at least two of their Activities of Daily Living, as previously defined.

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

Severe Burns

Definition: **Severe Burns** means a definite Diagnosis of third-degree burns over at least 20% of the body surface.

Stroke (cerebrovascular accident)

Definition: **Stroke (cerebrovascular accident)** means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, 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.

Exclusion: However, Stroke (cerebrovascular accident) does not include transient ischemic 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 purpose of this coverage, unless otherwise specified:

a) **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 Student.

b) **Diagnosis** means a written Diagnosis by a Health Specialist of the Student's Critical Illness. The effective date of the Diagnosis will be the date the Diagnosis is established by the Health Specialist as indicated by the Student's medical records. The date of Diagnosis must be after the effective date of insurance.

c) **Immediate Family** refers to the Spouse, Child, parent, brother, sister, father-in-law, mother-in-law, son-in-law, daughter-in-law, grandfather, grandmother, grandchild, step-brother or step-sister of the Student.

d) **Health Specialist** means a person who is licensed to practice medicine, who acts within the limits of licensure and who has completed graduate and clinical training in a specific field of medicine. Only a licensed Physician practicing in Canada falls within this definition. Excluded are the Student, a person living with the Student or their Spouse, the Child, parent, brother or sister of the Student or their Spouse.

4. CANCER AND BENIGN BRAIN TUMOR MORATORIUM EXCLUSION

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

- the date of Diagnosis for any Cancer or Benign Brain Tumour, whether covered or excluded under this coverage,
- the date the Student 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 Student 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 Student's effective date of coverage or date of date of reinstatement of the coverage, whichever is later.

5. INCREASE IN BENEFIT COVERAGE

Should an Student suffer 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 the Insurer, and should said Critical Illness result directly or indirectly from or be 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 the Insurer.

6. STUDENT'S DUTY TO DISCLOSE CANCER

The Student shall provide the Insurer, at its head office, with written notice informing the Insurer of the Student'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 Student or the last date of reinstatement of coverage for the Student, where applicable.

If this information is not provided within this period, the Insurer reserves the right to deny any claim for cancer or any Critical Illness caused by any cancer or its treatment.

7. OTHER EXCLUSIONS

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

1) Suicide or attempted suicide by the Student, 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) Operating a Vehicle while the Student is under the influence of any intoxicant, except if that intoxicant is consumed pursuant to a prescription issued by a Physician or nurse practitioner, and that no caution has been issued with respect to the effects of the consumption of such intoxicant on the operation of a Vehicle;

5) Operating a Vehicle while the Student's blood alcohol level is in excess of the legal limit in the jurisdiction where the incident occurred;

6) Operating a Vehicle while the Student has a blood drug or substance, or combination of substances, concentration in excess of the legal limit prescribed by the Criminal Code and its regulations at the time of the incident;

7) Voluntary inhalation by the Student of toxic gases, unless this inhalation occurs in the ordinary course of the Student's employment;

8) Consumption by the Student of medication, pharmaceutical products or legal drugs unless taken in accordance with the recommendations and prescription of a duly qualified Physician or nurse practitioner or in accordance with the instructions of a duly authorized pharmacist;

9) Consumption by the Student of illegal drugs;

10) Cosmetic surgery or any other treatment of a mainly esthetic nature; or

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

For the purposes of this coverage, is included the times when the Student was not of Sound Mind and all situations in which they were under the influence of narcotics, drugs, medications or alcohol, as well as any mental disorder or condition that prevents them from forming an intention.

8. SURVIVAL PERIOD

This coverage shall not apply and no benefit shall be payable if the Student does not survive for a period of at least 30 days following the date of Diagnosis of a Critical Illness 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 brain function.

9. TERMINATION

This coverage for the Student terminates automatically when a benefit is paid under this coverage or when they reach the age indicated in the Benefit Schedule, whichever comes first.

10. BENEFICIARY

The Student is the beneficiary.

The Student can dispose of the rights conferred by this insurance without obtaining the consent of the beneficiary, even if the beneficiary is irrevocable.

If a claim is received or approved after the death of the Student, the Student's estate will be deemed to be the beneficiary.

11. NOTICE AND PROOF OF CLAIM

In the event of a claim, the Policyholder or the Student must provide written notice to the Insurer within 31 days following the Diagnosis of the Critical Illness. The written notice given to the Insurer together with information identifying the Student constitutes a notice of claim in due form.

The Policyholder or Student must also, within 90 days following the Diagnosis of the Critical Illness, forward to the Insurer all information and supporting documentation that the Insurer may reasonably expect concerning the circumstances and extent of the claim. However, whenever a Student can demonstrate that it was impossible to act within the required period, they remain eligible to receive the benefit if all required claim documents are received by the Insurer within 12 months following the Diagnosis of the Critical Illness.

12. AUTOPSY

The Insurer reserves the right to request that an autopsy be performed on the deceased Student, to the extent permitted by law.

13. PAYMENT OF BENEFITS

Benefits provided for under this coverage are due within 30 days of receipt of the claim together with any supporting documentation necessary for adjudication by the Insurer, provided the claim is approved.

14. APPEALING A DECISION

Any Student who disagrees with a decision made by the Insurer may request a reconsideration 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 the reconsideration within 30 days following receipt of the written request. The Insurer will notify the Student in writing of the decision.

No request for reconsideration will be considered if it is received more than 12 months following 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 Student and shall not issue tax slips to the Student upon payment of this benefit.

HEALTH INSURANCE

1. SCOPE

Provided that this coverage is in force on the day an Insured Person incurs Eligible Expenses following Illness or Accident, the Insurer shall reimburse Eligible Expenses, subject to all other provisions of the contract and in accordance with the terms of payment outlined in the below section.

2. DEFINITIONS

For the 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 Insured Person 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 they have expertise that is pertinent to the case.

The **Convention** refers to those Drugs and Compounds 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 (CPS).

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 Usual, Customary and Reasonable 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 their Immediate Family, who is their business partner or who is their Employer; and

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

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

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

A **Health Specialist** means a person who is licensed to practice medicine, who acts within the limits of licensure and who has completed graduate and clinical training in a specific field of medicine. Only a licensed Physician practicing in Canada falls within this definition. Excluded are the Insured Person, a person living with the Insured Person or their Spouse, the Child, parent, brother or sister of the Insured Person or their Spouse.

Immediate Family refers to the Spouse, Child or parent of the Insured Person.

In Case of an Emergency or **Emergency** means a sudden and unforeseen Medical Condition that requires immediate Treatment

The **Maximum Amount** 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 Specialist, 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 Specialist. The Insurer reserves the right to evaluate what is considered Necessary From a Medical Point of View, and expenses could be refused based on this assessment.

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

A **Registered 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 their Immediate Family.

Usual, Customary and Reasonable Expense refers to the standard or most common charge or fee for a particular medical service when rendered in a particular geographic area. It is often employed in determining provincial healthcare payment amounts. Usual, Customary and Reasonable Expenses are split into three parts:

1) "usual charge or fees" are what the medical professional normally charges for a given procedure for treatment,
2) "customary charge or fees" are what the Insurer is willing to pay for a given procedure or treatment, and
3) "reasonable charge or fees" are fees the medical professional may charge when a procedure or treatment has complications or unusual circumstances.

3. CONDITIONS AND ELIGIBILITY

This coverage provides for the reimbursement of Usual, Customary and Reasonable 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 they are also eligible for the benefits available under government hospitalization plans and provincial health care programs.

Only Usual, Customary and Reasonable Expenses in excess of the fees paid or reimbursed by any government program will be reimbursed under this coverage.

4. ELIGIBLE EXPENSES

(a) Hospitalization Expenses in Canada

The Insurer pays, without any Deductible, the expenses for Hospitalization expenses in Canada in excess of those payable under any governmental insurance plan, up to the cost of a 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, deaf, 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 Usual, Customary and Reasonable Expenses:

(1) Fees incurred for the following services are eligible:

- 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. These services must be preauthorized ad supported by a medical prescription indicating:
  - The health condition and the prognosis;
  - The required services and their frequency; and.
  - The total expected duration of the services.

- Ambulance: When required but not covered by a Government Plan, the expenses for transportation by ambulance to or from the nearest Hospital that delivers the appropriate level of care, as well as air transport when the Insured Person cannot be transported by any other means, up to the Maximum Amount indicated in the Benefit Schedule;

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

- Laboratory tests, X-rays and ultrasounds up to the Maximum Amount indicated in the Benefit Schedule, rendered in the Insured Person's province of residence and only if the service is not covered under the Government Plan. Ultrasounds for maternity are covered only if this service is indicated in the Benefit Summary.
- Non-medical access-related expenses for a voluntary termination of pregnancy (abortion), up to the Maximum Amount indicated in the Benefit Schedule.

(3) The following expenses are eligible:

- Blood tests and health assessments for diagnostic purposes are covered, up to the maximum amount indicated in the benefits summary.
  - A blood test may include checks for various health indicators such as cholesterol, blood glucose, liver and kidney function, and levels of certain vitamins and minerals.
  - Any other diagnostic tests recommended by a physician are also covered.

- The following medical supplies, supported by a medical prescription, up to the maximum amount indicated in the Benefit Summary.
  - Purchase of compression garments for burns;
  - Purchase of external breast prostheses following a mastectomy;
  - Purchase of hair prostheses required due to a pathological condition or following chemotherapy treatment.

(c) Drug Expenses

No coverage is provided for the basic RAMQ drug plan.

The Insurer pays, after the Deductible and according to the percentage indicated in the Benefits Summary, the Usual, Reasonable and Customary Expenses:

- **Vaccines** not covered by RAMQ or any other provincial plan (excluding administration fees and allergy injections), up to the Maximum Amount indicated in the Benefit Schedule per Insured Person per Period of Coverage (Assumption Life 2nd payer)
- **Post-exposure prophylaxis (PEP)** for the prevention of HIV infection, up to the Maximum Amount indicated in the Benefit Schedule. (Assumption Life 2nd payer).

The Insurer pays the following Usual, Reasonable and Customary Expenses for generic drugs, after taking into account after the Deductible and according to the percentage indicated in the Benefits Summary:

- **Contraceptives** listed in the Benefits Schedule, registered and non-registered on the RAMQ list, up to the Maximum Amount indicated in the Benefits Schedule per Insured Person per Period of Coverage (Assumption Life 2nd payer)

- **Antidepressants**, registered and non-registered on the RAMQ list, up to the Maximum Amount indicated in the Benefits Schedule per Insured Person per Period of Coverage (Assumption Life 2nd payer)

- **Neurostimulants**, registered and non-registered on the RAMQ list, up to the Maximum Amount indicated in the Benefits Schedule per Insured Person per Period of Coverage (Assumption Life 2nd payer)

(d) Paramedical Expenses

The expenses for **paramedical services** provided by any of the practitioners listed in the Benefit Schedule, provided that these services are in their field of specialty and these professionals are members of their professional associations, up to the Maximum Amount indicated in the Benefit Schedule. The expenses for paramedical x-rays, if applicable, are included in the paramedical services Maximum Amount.

The practitioner cannot reside in the home of the Insured Person, be part of their Immediate Family, be their business partner or be their Employer.

(e) Vision Care Expenses

The Insurer pays for the following expenses:

(1) Eye examinations performed by a certified optometrist or ophthalmologist, up to the Maximum Amount indicated in the Benefit Schedule.

(2) The cost of corrective lenses and frames, prescription blue-light glasses or contact lenses, when purchased with a written prescription from a Physician or optometrist, up to the Maximum Amount indicated in the Benefit Schedule.

When the Insured Person suffers from severe astigmatism, severe corneal scarring, or keratoconus, the limit provided in paragraph 2) above will never be less than $200.

(3) Laser vision correction, up to the Maximum Amount indicated in the Benefit Schedule.

(4) The following additional eye tests, provided they are performed by an authorized eye specialist, up to the Maximum Amount indicated in the Benefit Schedule:

- Follow-up examination;
- Contact lens examination for Keratoconus, orthokeratology examination;
- Low vision examination;
- CS scan for glaucoma or retina assessment;l
- Retinal imagine;
- Cycloplegia for children;
- Cycloplegia / Dilatation for adults;
- SAAQ form, file summary of other forms;
- Eye Emergency;
- Emergency follow-up;
- Ocular Emergency with OTC (flash or loss of vision including scan, imagine, dilation)

5. COORDINATION OF BENEFITS

If benefits are claimed under more than one section of this Policy, 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 Insured Person 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 an Employee takes priority over any amount payable by a plan that insures the person as a Dependent. If the Student is a member of more than one plan as an employee, priority is set as follows:

- The plan where the Student is an active full-time employee;
- The plan where the Student is an active part-time or seasonal employee; then
- The plan where the Student is a retiree.

(c) The amount of benefits payable under a plan under which the person is insured as an Insured Person or Student takes precedence over the amount payable under a plan insuring this person as a Dependent. If the Insured Person participates in more than one plan as a Student, the order of precedence is established as follows:

- The plan in which the Insured Person participates as a full-time Student*; then,
- The plan in which the Insured Person participates as a part-time Student*.

*The status of full-time or parti-time Student is determined by the educational institute. If the Insured Person participates in more than one insurance plan as an Insured Person with the same status, the order of precedence of the first payer is established according to the one with the earliest coverage start date under the plan.

(d) When a Dependent is insured under more than one insurance plan, the plan of the Student 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 priority is set as follows for this Dependent:

- The plan of the parent with custody of the Child.
- The plan of the spouse of the parent with custody of the Child.
- The plan of the parent not having custody of the Child.
- The plan of the spouse of the parent not having custody of the Child.

(f) For dental Accidents, if the Student is covered under both a health plan with accidental dental coverage and a 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

The Student and Dependent coverage, if applicable, under this plan terminates automatically when the Student 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 Usual, Customary and Reasonable Expenses.

(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 worker'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 adjustment or maintenance of hearing aids.

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

(10) Expenses related to gender affirmation medical care procedures and all associated expenses.

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

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

(13) Expenses incurred following:

- self-inflicted injuries, physical or mental damage, whether the Insured Person was of Sound Mind or not at the time;
- injuries sustained while the Insured Person was taking part in a criminal offence or an attempted criminal offence;
- injuries sustained by the Insured Person during active participation in a civil unrest, a riot, an insurrection, or a military action, whether or not war has been declared;

(14) Expenses incurred outside Canada when the medical condition of the Insured Person would have allowed him to return home but they refused.

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

(16) Expenses that would not normally have been charged to the Insured Person if they had not been covered by this Policy.

(17) Expenses for cosmetic procedures or those not considered Necessary From a Medical Point of View.

(18) Contact lenses following cataract surgery.

(19) Costs for insulin infusion pumps.

(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 Student and, if applicable, their 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 their behalf must notify the Insurer within 24 hours of the Accident or Illness giving rise to Eligible Expenses under this benefit, or as soon as possible if they are unable to do so.

In the event of a request for payment, the Insured Person must present their 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 Student 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.

Claims payments if this Policy terminates:

In the event of termination of this Policy, claims must be sent to the Insurer within 90 days of the Policy termination. Any claims received more than 90 days after the termination date of this Policy will not be reimbursed, regardless of when the Eligible Expense was incurred.

9. SURVIVOR BENEFITS

If, at the time of the Student's death, their Dependents are covered by this current coverage, their insurance will remain in force, without further payment of premiums. However, this coverage will cease on the first of the following dates:

(a) The date that this insurance Policy terminates.

(b) The end date of the Student's current academic year.

(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 Student.

DENTAL INSURANCE

1. SCOPE

Provided that this coverage is in force when an Insured Person incurs expenses, the Insurer will reimburse Eligible Expenses deemed Necessary From a Medical Point of View, 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 members of a provincial association of their respective professional body or, under the supervision of the latter, a dental hygienist or any member of their 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 Insured Person becomes covered as long as the Insured Person enrolls for this coverage within 31 days of the date that they become eligible for this coverage.

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.

A **Consultation** takes place when the Insured Person is referred by a Health Specialist for an appointment with another Health Specialist who can make recommendations or provide an opinion because they have expertise that is pertinent to the case.

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.

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 Usual, Customary and Reasonable;
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 their Immediate Family, who is a business partner or who is their employer; or
f) were incurred while this coverage was in force.

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

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

A **Health Specialist** means a person who is licensed to practice medicine, who acts within the limits of licensure and who has completed graduate and clinical training in a specific field of medicine. Only a licensed Physician practicing in Canada falls within this definition. Excluded are the Insured Person, a person living with the Insured Person or their Spouse, the Child, parent, brother or sister of the Insured Person or their Spouse.

Immediate Family refers to the Spouse, Child or parent of the Insured Person.

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. The Insurer reserves the right to evaluate what is considered Necessary From a Medical Point of View, and expenses could be refused based on this assessment.

Period, as outlined in the Benefit Schedule, refers to the frequency of coverage for the services included in the Eligible Expenses section.

Usual, Customary and Reasonable Expense refers to the standard or most common charge or fee for a particular medical service when rendered in a particular geographic area. It is often employed in determining provincial healthcare payment amounts. Usual, Customary and Reasonable Expenses are split into three parts:

1) "usual charge or fees" are what the medical professional normally charges for a given procedure for treatment,
2) "customary charge or fees" are what the Insurer is willing to pay for a given procedure or treatment, and
3) "reasonable charge or fees" are fees the medical professional may charge when a procedure or treatment has complications or unusual circumstances.

3. ELIGIBLE EXPENSES

The Insurer pays, after subtracting the Deductible, based on the percentage indicated for this purpose in the Benefit Schedule, the Usual, Customary and Reasonable Expenses for dental services described below.

PART I – A – Diagnosis and Prevention

Subject to the coverage percentage indicated for Part I in the Benefit Schedule, the following Eligible Expenses for Basic Care are eligible for reimbursement. They are subject to the Deductible, the maximums outlined in the Benefit Schedule, and the conditions and restrictions below, if applicable.

(a) Diagnosis and Prevention

(1) X-rays:

- One complete series of x-rays up to a maximum of one series per 36 consecutive months;
- A panoramic x-ray up to a maximum of one film per 36 consecutive months;
- Bite wing x-rays up to a maximum of one series of 2 units per12 consecutive months; and
- Intra-oral photograph up to a maximum of 4 per 12 consecutive months;

(2) Oral hygiene instructions once every 12 consecutive months;

(3) Laboratory tests;

(4) Tooth polishing: limited to 1 unit per 6 consecutive month;

(5) Teeth scaling, up to a maximum of 2 units per 12 consecutive months;

(6) Topical fluoride application up to a maximum of 1 treatment per 6 consecutive months;

(7) Retainers in the absence of primary teeth, for children under 16 years;

(8) Filling finishing, pit and fissure sealing, interproximal grinding and prophylactic odontotomy/ameloplasty.

(b) Recall Exam

(1) Clinical oral examination:

- The initial full examination up to a maximum of one such examination per 36 consecutive months;
- A recall or periodic examination, up to a maximum of one per 6 consecutive months;
- Additional examinations or Consultations (with the exception of orthodontic treatments).

PART I – B– Basic Care

(a) Minor Restoration

Amalgam based restorations (non-bonded), restoration using silicate and acrylic or composite resin restorations (bonded and non-bonded), retention posts for amalgam or composite retention, prefabricated crowns for children under 16, and separate restorative procedures for caries, trauma and pain control. Composite (white) fillings are only covered for front teeth.

Repaid of a removable prosthesis, up to a maximum outlined in the Benefit Schedule.

Repaid of fixed prostheses, up to a maximum outlined in the Benefit Schedule.

Sedative dressings.

(b) Oral Surgery

Eligible Expenses in this category includes:

- Tooth extractions (including wisdom teeth, including anesthesia)
- Removal or residual root
- Surgical exposure of teeth
- Alveoplasty, gingivoplasty, stomatoplasty and osteopathy
- Reconstruction of the alveolar process
- Extension of mucosal folds
- Excisions
- Incisions
- Frenectomy
- Other miscellaneous surgical procedures

(c) Endodontics

(1) Treatment of pulp chamber disease (Root canal therapy)

(d) Periodontics

(1) Treatment of soft tissue (gums) and bone

Expenses limited to:

- Post-operative visits, 4 visits per Coverage Period;
- Curettage by a dentist, 1 per 60 month Period;
- Periodontal appliance adjustment, 1 adjustment per Coverage Period;
- Root planning, 8 units of 15 minutes per Coverage Period;
- Bite correction, 8 units of 15 minutes per Coverage Period;

4. COORDINATION OF BENEFITS

If benefits are claimed under more than one section of this Policy, 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 Insured Person 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 an Employee takes priority over any amount payable by a plan that insures the person as a Dependent. If the Student is a member of more than one plan as an employee, priority is set as follows:

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

(c) The amount of benefits payable under a plan under which the person is insured as an Insured Person or Student takes precedence over the amount payable under a plan insuring this person as a Dependent. If the Insured Person participates in more than one plan as a Student, the order of precedence is established as follows:

(1) The plan in which the Insured Person participates as a full-time Student*; then,
(2) The plan in which the Insured Person participates as a part-time Student*.

*The status of full-time or parti-time Student is determined by the educational institute. If the Insured Person participates in more than one insurance plan as an Insured Person with the same status, the order of precedence of the first payer is established according to the one with the earliest coverage start date under the plan.

(d) When a Dependent is insured under more than one insurance plan, the plan of the Student 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 priority is set as follows 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 Student is covered under both a health plan with accidental dental coverage and a 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

The Student and Dependent coverage, if applicable, under this plan terminates automatically according to the ages 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 exceeding the Maximum 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 they became eligible for coverage.

(c) Exclusions

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

(1) Expenses exceeding those deemed Usual, Customary and Reasonable Expenses for the least expensive dental procedure recognized as acceptable in dental medicine;

(2) That part of the expenses covered by worker'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 related to the purchase of dental prostheses, except for the purchase of a single dental prosthesis that became necessary as a result of an Accident that occurred while this benefit was in effect.

(8) 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;

(9) Expenses charged by a dental surgeon for an appointment that the Insured Person missed or for completing any insurance form or other documents;

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

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

(12) Expenses incurred following:

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

(13) Any expense not listed among the Eligible Expenses.

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

6. TERMS FOR APPLYING THE DEDUCTIBLE

The amount of the Deductible is indicated in the Benefit Schedule. The Deductible is applied only once per calendar year to the aggregate of the Eligible Expenses for all Parts of coverage incurred by the Student and, if applicable, his or her 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 $200.

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 exceeding $200 in order to avoid any unexpected refusals.

8. NOTICE AND PROOF OF CLAIM

In the event of a request for payment, the Insured Person must present their 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, 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. If the cost of a single treatment exceeds $200, x-ray, photos, study models should be sent before treatment is rendered as per Preliminary Assessment Section of this Policy.

The Student 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 this Policy terminates:

In the event of termination of this Policy, claims must be sent to the Insurer within 90 days of the Policy termination. Any claims received more than 90 days after the termination date of this Policy will not be reimbursed, regardless of when the Eligible Expenses was incurred.

9. SURVIVOR BENEFITS

If, at the time of the Student's death, their Dependents are covered by this current coverage, their insurance will remain in force, without further payment of premiums. However, this coverage will cease on the first of the following dates:

(a) The date that this insurance Policy terminates.

(b) The end date of the Student's current academic year.

(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 Student.