Health Coverage Choice

Health and Dental Choice A
Series 9.01

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

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

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

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

Signed at Waterloo, Ontario

IMPORTANT NOTICE – PLEASE READ CAREFULLY

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

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

Table of contents

Policy particulars

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

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

ATTENTION: THE POLICY INCLUDES RESTRICTED BENEFITS

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

Payment schedule

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

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

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

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

We may apply an administrative fee if a payment is returned.

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

Plan summary

Benefit	Reimbursement	Maximum per person
Drug	80%	$500 in a calendar year
Extended health	80%	Described in the *Extended health provision* section
Vision	100%	$150 every two calendar years
Semi-private hospital room	50% of reasonable and customary charges	$5,000 in a calendar year Described in the *Semi-private hospital room provision* section
Preventive dental	80%	$700 in a calendar year

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

Drug (for Quebec residents only)

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

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

Lifetime maximum

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

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

If you change your mind within 10 days

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

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

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

If you want to cancel your policy at any time

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

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

Sun Life Assurance Company of Canada
PO Box 1601, Stn Waterloo
Waterloo ON N2J 4C5

Nurse Practitioner

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

Drug provision

Prescription drugs

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

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

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

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

Eligibility criteria for drugs and drug supplies

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

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

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

Generic substitution

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

Exclusions

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

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

Extended health provision

Eligible expenses

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

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

We will pay for the services of the paramedical practitioners listed below. To qualify as an eligible expense, the service performed must be within the paramedical practitioner's area of expertise and require the skills and qualifications of that practitioner.

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

The amount we pay is limited to a maximum of $25 per visit and calendar year maximum of $250 for each type of paramedical practitioner except for psychologist or social worker.

The amount we pay for the services of a psychologist or social worker is limited to $60 per visit and calendar year maximum of $300.

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

We will pay for the services of a dental surgeon required to treat a fractured jaw or accidental injuries to natural teeth if the fracture or injury was caused by external, violent and accidental means. These services include a dental prosthesis. We will not pay for any services required to treat a fracture or injury because of a condition that existed before the fracture or injury. The amount we pay is limited to $2,000 per fracture or injury. Services must be performed within 12 months of the date of the fracture or injury. We do not require a physician's prescription for these services to be eligible.

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

We will pay for hearing aids and repairs to them, excluding batteries, limited to $300 per each five year period. The five year period begins from the date the first expense is incurred. We will pay when we receive proof that the insured person has applied for the applicable government funding for this service.

We will pay for the following provincially funded services and equipment, limited to a combined calendar year maximum of $2,500 and a combined lifetime maximum of $20,000.

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

- artificial limbs or other prosthetic appliances,
- braces, provided they are not solely for athletic use,
- oxygen,
- walker, if we have approved either its purchase or rental,
- wheelchair, limited to a lifetime maximum of $1,000, if we have approved either its purchase or rental, and
- repairs to durable medical equipment we cover under this policy will be reimbursed up to the percentage indicated on the *Plan summary* page.

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

- continuous glucose monitor receivers, transmitters or sensors, only for persons diagnosed with Type 1 diabetes. The insured person must provide us with a doctor's note confirming the diagnosis,
- blood glucose monitors, limited to $150 per each five year period,
- diagnostic laboratory tests and x-ray examinations,
- custom made orthopaedic shoes, orthopaedic modifications to shoes, and orthotics, when they are required to correct a deformity of the bones and muscles and not solely for athletic use. They must be prescribed by a physician, podiatrist, chiropodist or chiropractor. The amount we pay is limited to $200 in a calendar year,

- durable equipment (but not walkers or wheelchairs) if we have approved either its purchase or rental. An example of durable equipment in this provision is a hospital bed or a traction kit. For hospital beds, the amount we pay is limited to a lifetime maximum of $1,500,
- plaster of paris or fibreglass casts,
- splints and crutches,
- wigs and hairpieces required as a result of alopecia, chemotherapy, or radiation therapy, limited to a lifetime maximum of $100, and
- repairs to durable medical equipment we cover under this policy will be reimbursed up to the percentage indicated on the *Plan summary* page.

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

Exclusions

We will not pay for:

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

Vision care provision

Eligible expenses

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

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

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

Exclusions

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

Semi-private hospital room provision

Eligible expenses

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

Eligible expenses mean the reasonable and customary charges for semi-private accommodation in a hospital limited to a calendar year maximum of $5,000.

If the insured person was pregnant when they applied for personal health insurance, we will only pay up to two days of hospitalization due to the pregnancy.

Exclusions

We will not pay for:

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

Dental provision

Eligible expenses

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

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

Description of coverage

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

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

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

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

How claims are paid

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

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

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

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

What is covered

The following dental procedures are considered eligible expenses.

Preventive dental procedures

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

Limitations

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

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

Exclusions

We will not pay for:

- replacement of periodontal appliances and space maintainers which have been lost, stolen or misplaced,
- expenses incurred for the treatment of malocclusion or for orthodontic treatment,
- services rendered in conjunction with surgical services payable under a government plan,
- full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
- dental services required due to congenital malformation,
- charges for appointments that an insured person does not keep,

- charges for completing claim forms, and
- expenses incurred under any of the conditions specified in the *When we will not pay (exclusions)* section of the *Other information about your policy* pages.

Making a claim for benefits

When to make a claim

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

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

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

Payment of claims

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

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

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

For each eligible expense, we compare:

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

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

Eligibility requirements

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

- a resident of Canada,
- covered under provincial or territorial health and drug insurance,
- Quebec residents must also have and continue to have health and drug coverage through a group benefit plan or through Régie de l'assurance maladie du Québec (RAMQ). A person not covered under a group benefit plan or through RAMQ, is not eligible for coverage under this policy.
- related to you in one of the following ways:

- spouse:
  - your spouse by marriage or under any other formal union recognized by law, or
  - a partner of the opposite sex or of the same sex who is living with you and has been living with you in a conjugal relationship for at least one year. If you reside in Quebec, there is no minimum cohabitation period for common-law spouses if a child is born out of their relationship.

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

  You must provide us proof of the above within six months of the date the child attains the age limit.
  - a child who becomes disabled before the age limit and remains continuously disabled, qualifies as long as the child:
    i) is incapable of financial self-support because of a disability,
    ii) depends on you for financial support, and
    iii) does not have a spouse.

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

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

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

Applying for changes to your policy

Adding an insured person

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

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

You may apply to add any child who is:

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

i) is incapable of financial self-support because of a disability,
ii) depends on you for financial support, and
iii) does not have a spouse.

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

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

Removing an insured person

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

When your policy ends

Your coverage will end on the earliest of:

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

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

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

Other information about your policy

Information about our contract with you

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

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

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

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

Recovering payments from a third party (Subrogation)

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

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

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

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

Currency of this policy

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

Premiums

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

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

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

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

Grace period

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

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

Right to copies of documents

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

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

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

Other insurance

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

Integration with government programs

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

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

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

When we will not pay (exclusions)

We will not pay for:

- expenses that we are not legally allowed to pay,
- for services or items that we consider cosmetic,
- for services or items that we consider experimental,
- for delivery, transportation and administration charges,
- for services and products that are self-prescribed or are rendered or prescribed by a person who is ordinarily a resident in the insured person's home or who is related to the insured person by blood or marriage,
- for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described in *Integration with government programs* unless explicitly listed as covered under this benefit,
- services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments. Experimental or investigational treatments mean treatments that are not approved by Health Canada or other government regulatory body for the general public,
- for services or supplies that do not qualify as medical expenses under the *Income Tax Act (Canada)*, and
- elective (non-emergency) medical treatment or surgery which is received or performed out of the province where they the insured person lives.

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

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

Insurance terms

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

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

Paramedical Practitioners	Paramedical practitioners must be qualified. Qualified means a person who is a member of the appropriate governing body established by the provincial government for their profession. In the absence of a governing body, the person must be an active member of an association approved by us. Qualified paramedical practitioners must: • belong to a regulatory body or in the absence of a regulatory body, belong to an association approved by us, • be licensed or registered, as required by the applicable provincial regulatory body, • have undergone appropriate training and obtained necessary credentials in support of the services or supplies rendered, • maintain clinical records and files consistent with the reasonable practices and standards of others in their field or as may be required by a regulatory body or association, • produce clinical records and files to us upon request and generally act in a manner that is responsive to inquiries from us, and • not engage in administrative practices unacceptable to us. This is not an exhaustive list of qualifications. We have the sole discretion to determine whether a paramedical practitioner is qualified to render a service or provide a supply. To the extent that the qualifications listed above apply to clinics, we have the sole discretion to determine whether a clinic is qualified such that claims for services or supplies rendered at that clinic are eligible for reimbursement under this plan.
Physician	a doctor of medicine (M.D.) licensed to practice medicine.
Policy anniversary	the month and day every year that is the same as the *Effective date of your policy* shown on the *Policy particulars* page.
Reasonable and customary charges	for dental professional fees, fees which are usually charged to a person without insurance and which are not greater than the fees in the dental fee guide. for health expenses and dental laboratory charges, mean amounts which are usually charged to a person without insurance and are not greater than the general level of charges in the area where the expenses are incurred.

Statutory conditions

1. The contract

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

Waiver

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

Copy of application

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

2. Termination of insurance

1) The contract may be terminated:

   a) by the insurer giving to the insured 15 days' notice of termination by registered mail or five days' written notice of termination personally delivered; or

   b) by the insured at any time on request.

2) If the contract is terminated by the insurer:

   a) the insurer must refund the excess of premium actually paid by the insured over the prorated premium for the expired time, but in no event may the prorated premium for the expired time be less than any minimum retained premium specified in the contract; and

   b) the refund must accompany the notice.

3) If the contract is terminated by the insured, the insurer must refund as soon as is practicable the excess of premium actually paid by the insured over the short rate premium calculated to the date of receipt of the notice according to the table in use by the insurer at the time of termination.

4) The 15-day period mentioned in clause (1)(a) of this condition starts to run on the day following the day the registered letter or notification of it is delivered to the latest postal address of the insured on the records of the insurer.

3. Material facts

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

4. Notice and proof of claim

1) The insured or a person insured, or a beneficiary entitled to make a claim, or the agent of any of them, must:

   a) give written notice of claim to the insurer not later than 30 days after the date a claim arises under the contract on account of an accident, sickness or disability,

      (i) by delivery of the notice, or by sending it by registered mail, to the head office or chief office of the insurer in the province/territory; or

      (ii) by delivery of the notice to an authorized agent of the insurer in the province/territory;

b) within 90 days after the date a claim arises under the contract on account of an accident, sickness or disability, provide to the insurer such proof, as is reasonably possible in the circumstances, of:

(i) the happening of the accident or the start of the sickness or disability;

(ii) the loss caused by the accident, sickness or disability;

(iii) the right of the claimant to receive payment;

(iv) the claimant's age; and

(v) if relevant, the beneficiary's age; and

c) if so required by the insurer, provide a satisfactory certificate as to the cause or nature of the accident, sickness or disability for which claim is made under the contract and, in the case of sickness or disability, its duration.

5. Failure to give notice or proof

2) Failure to give notice of claim or provide proof of claim within the time required by this condition does not invalidate the claim if:

a) for residents of Saskatchewan,

a. the notice or proof is given or provided as soon as reasonably possible, and not later than the limitation period set out in *The Limitations Act* after the date of the accident or the date a claim arises under the contract on account of sickness or disability, and it is shown that it was not reasonably possible to give the notice or provide the proof in the time required by this condition, or

b. in the case of the death of the person insured, if a declaration of presumption of death is necessary, the notice or proof is given or provided no later than the limitation period set out in *The Limitations Act* after the date a court makes the declaration.

b) for residents of any other province, the notice or proof is given or provided as soon as reasonably possible, and in no event later than one year after the date of the accident or the date a claim arises under the contract on account of sickness or disability, and it is shown that it was not reasonably possible to give the notice or provide the proof in the time required by this condition, or.

c) for residents of Alberta, British Columbia, Manitoba and Ontario, in the case of the death of the person insured, if a declaration of presumption of death is necessary, the notice or proof is given or provided no later than one year after the date a court makes the declaration.

6. Insurer to provide forms for proof of claim

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

7. Rights of examination

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

a) the claimant must give the insurer an opportunity to examine the person of the person insured when and as often as it reasonably requires while a claim is pending,

b) in the case of death of the person insured, the insurer may require an autopsy, subject to any law of the applicable jurisdiction relating to autopsies, and

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

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

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

9. Limitation of actions

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

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