Assumption Life
Group Insurance

New Brunswick Massage Therapist Association

All Eligible Employees

Contract Number: **14017**
Effective Date: **1 August 2018**
Prepared on: 27 July 2018

The purpose of this booklet is to provide you with the principal features of your group program. As such, it has no contractual value. Only the terms and provisions of the contract between the Policyholder and the Insurer prevail.

The information contained in this booklet will answer most of the questions related to your group coverage. Additional information may be obtained from your Group Administrator or Group Representative.

Assumption Life
P.O. Box 160 / 770 Main Street
Moncton NB E1C 8L1
1-888-869-9797

Create your Assumption Life Group Insurance eProfile™ account

In order to register for online access, you must have:

- Active benefit card
- Valid email address

Visit www.claimsecure.com

Select « *Login* » from the drop-down options under the **eProfile™ Services** tab.

Click Register Now , then Start

Step 1: Terms and Conditions
Read and agree, then click I Agree

Step 2: Wellness Profile (optional)
Select the options you wish to add to your profile, click Next

Step 3: User Profile
Enter your personal information in the mandatory fields, click Next

Step 4: Direct Deposit Information
Fill out your direct deposit information for faster reimbursement! Click Submit

You have now created your eProfile™.

Access your eProfile™ account from your smartphone.

Go to www.claimsecure.com on your smartphone to download the mobile application and follow instructions.

How to submit a claim

1. PhotoClaims
2. Choose benefit type
3. Take a picture of your receipt
4. Submit claim

Powered by claimsecure

SCHEDULE OF BENEFITS

PLAN 14017CL01

GROUP LIFE INSURANCE

Amount of life insurance	$25,000
Maximum amount of insurance	$25,000
Proof of insurability required for amounts exceeding	$25,000

Benefits will be reduced:

by 50% when the participant reaches 65 years of age.

Benefits for a participant terminate at the earliest of the following dates:

a. on the participant's 75th birthday
b. the date of the participant's retirement
c. the date on which the insurance terminates

* *If applicable, the reduction is always based on the previous coverage.*

All amounts of insurance are rounded to the next $1,000.

Waiver of Premium

If, prior to your 65th birthday, you become totally disabled and if you remain totally disabled without interruption for at least 6 months, the insurer waives collection of any future premiums for this coverage for as long as the total disability continues.

OPTIONAL LIFE INSURANCE

Amount of optional life insurance	$250,000
Proof of insurability required for amounts exceeding	$0

The amount of additional life insurance cannot be in excess of $250,000 or lower than $10,000.

Benefits will terminate upon the earliest of the following:

a. The date on which the participant reaches 70 years of age.
b. The date of his/her retirement.
c. The date on which his/her insurance terminates.

DEPENDENT LIFE

Spouse - $10,000 Children - $5,000

Benefits for insured dependents terminate at the earliest of the following dates:

a. on the participant's 75th birthday
b. the date of his/her retirement
c. the date on which his/her insurance terminates

The term *Dependent* is defined in the General Provisions section of your booklet.

ACCIDENTAL DEATH AND DISMEMBERMENT

Amount of life insurance	$25,000
Maximum amount of insurance	$25,000
Proof of insurability required for amounts exceeding	$25,000

INDEMNITIES FOR LOSS OF	PERCENTAGE PAYABLE
Loss of One Arm	75%
Loss of Entire Sight of One Eye	66.67%
Loss of Entire Sight of Both Eyes	100%
Loss of Both Feet	100%
Loss of Four Fingers of The Same Hand	33.33%
Loss of One Foot	66.67%
Loss of One Foot and Sight of One Eye	100%
Loss of One Hand	66.67%
Loss of one Hand and Sight of One Eye	100%
Loss of One Hand And One Foot	100%
Loss of Both Hands	100%
Loss of Hearing in One Ear	25%
Total Paralysis of Upper and Lower Limbs	200%
Loss of Hearing in Both Ears	50%
Loss of One Leg	75%
Accidental Death	100%
Total Paralysis of Both Lower Limbs	200%
Total Paralysis of Both Upper and Lower Limbs	200%
Loss of Speech	50%
Loss of Speech and Hearing in Both Ears	100%
Loss of Thumb and Index Finger Same Hand	33.33%
Loss of Use of One Arm	75%
Loss of Use of One Hand	66.67%
Loss of Use of Both Hands	100%
Loss of Use of One Leg	75%

Benefits will be reduced:

by 50% when the participant reaches 65 years of age.

Benefits for a participant terminate at the earliest of the following dates:

a. on the participant's 75thbirthday
b. the date of the participant's retirement
c. the date on which the insurance terminates

* *If applicable, the reduction is always based on the previous coverage.*

All amounts of insurance are rounded to the next $1,000.

HEALTH CARE INSURANCE

Hospitalization	N/A

Drug Plan

Direct-payment with pay-direct card	Plan AGMF
Co-payment	20% maximum $25 per prescription
Benefit maximum	$7,500 per insured person per calendar year
Deductible	$0 Individual $0 Family

Formulary Protect Plus:

1) All drugs that by the law or convention require a prescription from a physician or a dentist and that is included in our drug formulary. Our drug formulary provides coverage for most commonly prescribed medications while excluding certain Specialty Drugs. Specialty drugs are those used to treat medical conditions with an expected annual treatment cost that may have catastrophic impacts on the long-term viability of your insurance program. This program is specifically designed to help you save on insurance costs at all times by allowing you and your colleagues make the most efficient use of all health resources available. Based on clinical evaluation and authorization criteria, Specialty Drugs may be available when you need them through your provincial drug program, special private or public drug access programs, or may be covered under your drug plan.

2) Should you require access to one of the excluded Specialty drugs, this program will provide you with privileged access to our unique Coverage Navigation Services that will help you and your physician identify and register with the best applicable drug access program.

Mandatory Drug Plan - There are two situations in which the brand name drug would be dispensed:

- The insured member can pay the cost differential between the brand name and generic drug, or
- If the insured member experiences an adverse drug reaction to the generic drug **(could be required to have tried two generic drugs in some cases.)** The member must submit to Assumption Life an Adverse Drug Reaction form completed by a physician along with the No Substitution form. These forms are available on Assumption Life's Website at www.assumption.ca under the Group Insurance section.

When the insured resides in a province offering a government drug insurance program, the insurer covers eligible prescription drugs under this plan while adhering to the maximum contribution limit that may be fixed for the insured and based on the amount of coinsurance set by the applicable legislation, if necessary.

Specialty Drug Program

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

Extended Health

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

Deductible	$0 Individual $0 Family
Reimbursement	100%

Paramedical Services
The expenses for paramedical x-rays, if applicable, are included in the paramedical services maximum amount.

Practitioners	Co-ins.	Per visit	Maximum	Frequency
Acupuncturist	100%	$0	$500	Calendar Year
Chiropractor	100%	$0	$500	Calendar Year
Dietician	100%	$0	$500	Calendar Year
Naturopath, Homeopath	100%	$0	$500	Calendar Year
Occupational Therapist	100%	$0	$500	Calendar Year
Osteopath	100%	$0	$500	Calendar Year
Podiatrist, Chiropodist	100%	$0	$500	Calendar Year
Psychologist	100%	$0	$500	Calendar Year
Speech-language pathologist	100%	$0	$500	Calendar Year

Other Expenses

Services	Maximum	Frequency
Breast Prosthesis	$150	24 consecutive months
Hearing Aid	$500	36 consecutive months
Laboratory test and X-Rays	$500	12 consecutive months
Nursing Services	$10,000	Calendar Year
Intra Uterine Device	$400	60 consecutive months
Orthopaedic Footwear and Insoles	$400	12 consecutive months

Vision Care

Reimbursement: 100%

- Expenses for **eye examination** by an authorized optometrist or ophthalmologist, **eyeglasses (including frames)**, **contact lenses** or **laser surgery** prescribed by a physician or an optometrist, up to $200 per person per period of 24 consecutive months.

Second Medical Opinion Services

Second Medical Opinion Services are offered to all employees covered by their health insurance plan including their dependents.

Health and Wellness Program

Health and Wellness Program is offered to all employees covered by their health insurance plan including their dependents.

Travel Insurance

Reimbursement: 100%

Maximum CAN$ 2,000,000 / insured person.

Benefits for a participant and, if applicable, for insured dependents terminate upon the earliest of the following events:

a. the date on which the participant reaches 85 years of age; 75 **for travel insurance;**
b. the date of the participant's retirement;
c. the date on which the insurance terminates.

Furthermore, benefits for insured dependents shall end on the date the insured dependent reaches 85 years of age, 75 for travel insurance, if this date precedes an event described above.

Convalescent Hospital

The charges made for a convalescent hospital room board and other necessary services, in excess of the charge for ward accommodation, up to a maximum of $40 per day will be considered eligible expenses. However, the person insured must be admitted to the convalescent hospital within 14 days following a period of at least five consecutive days as a bed patient in a hospital. Expenses will be deemed as eligible only where convalescent hospitalization is prescribed by the attending physician. Benefits shall be paid for a maximum period of 120 days during any one period of disability. All confinements in a convalescent hospital will be considered as a one period of disability, unless separated by at least 90 days. In order to qualify under these covered expenses, the convalescent hospital must be approved by the appropriate Provincial Housing Authority. Charges for custodial care in a convalescent hospital, nursing home or similar institution will not be considered eligible expenses.

DENTAL CARE INSURANCE

Deductible:	Individual	$0
	Family	$0

		Coinsurance
Part I	Basic (Diagnostic, prevention, oral surgery, minor restoration, repair of prosthesis)	80%
	Endodontic	80%
	Periodontic	80%
Part II	Major Restoration	N/A
Part III	Prosthodontics	N/A
Part IV	Orthodontics (child less than 21 years)	N/A

Maximum expenses per insured:
Part I per calendar year $2,500

*The recall exam is limited to one every 12 months
*The scaling is paid on a 12 consecutive month frequency.

Eligible expenses are based on the current Dental Fee Guide in force in the insured person's province of residence .

Benefits for a participant and, if applicable, for insured dependents terminate upon the earliest of the following events:

a. The date on which the participant reaches 85 years of age;
b. The date of the participant's retirement;
c. The date on which the insurance terminates.

Furthermore, benefits for insured dependents shall end on the date the insured dependent reaches 85 years of age if this date precedes an event described above.

When dental work is recommended and the approximate cost is expected to exceed $300, a claim form describing the proposed treatment should be sent to us for approval.

ELIGIBILITY

Eligibility of Employee

An employee becomes eligible for insurance on the day he or she has satisfied the eligibility period requirement stated in the summary of benefits of the contract and is a permanent full-time employee actively working at least 20 hours per week.

Eligibility of Dependents

Children : Over 24 hours of age, and younger than 21 years of age; or 21 years of age or more, but younger than 26 years of age if he or she is a regular full-time student attending an accredited educational institution.

GENERAL PROVISION

Eligibility

An employee becomes eligible for insurance on the day he or she has satisfied the eligibility period of the contract and is a permanent full-time employee actively working at least the number of hours per week requirement stated in the summary of benefits. An employee who is not actively working on a full-time basis on the day when he or she would otherwise be eligible for insurance, becomes eligible at the date of his or her return to active work on a full-time basis.

Eligibility of Dependents

Coverage for eligible dependents will commence on the same date as the employee or at the date they subsequently become dependents. Application for dependent coverage must be made within 31 days of their becoming eligible. If not, proof of insurability will be required before coverage is approved.

Dependents

If benefits are provided for your dependents, the following definitions apply:

Spouse: - His or her spouse, that is the only person considered his or her spouse either:

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

b) through permanent cohabitation with the employee for more than one year and openly presented by the employee as being his or her spouse; or,

Note : For Quebec residents

c) the person with whom the member cohabits in a conjugal relationship, having had a child together, and who has not been separated for more than 90 days as a result of a marital break-up.

Children: your unmarried dependent children, provided they meet the age requirements as indicated in the summary of benefits.

Regardless of his or her age, is stricken with a physical or mental disability resulting from an accident or sickness that requires regular medical care. The disability shall have begun while the child was a dependent, as previously defined, and of such nature that the dependent is totally incapable of pursuing a gainful occupation.

Effective Date of Insurance

The insurance of an employee and of any eligible dependent takes effect at the latest of the following dates:

- the date of eligibility, if the insurance application is received by the insurer within 31 days following this date; or,
- the date the insurer receives and accepts the proof of insurability submitted as a result of the insurance application being submitted later than 31 days after the date of eligibility.

Any insurance coverage or part thereof which requires proof of insurability shall only take effect on the day the insurer accepts such proof of insurability. The date of acceptance shall be the date the insurer receives such final proof of insurability.

Termination of Insurance

The coverage provided by this contract automatically terminates upon the earliest of the following dates:

- the termination date of the Contract;
- the date the participant is no longer employed by the employer;
- the date the participant is no longer eligible;
- the day the participant makes misrepresentations or commits a fraudulent act against the insurer;
- the date the insurer receives a written notice of termination by the Policyholder or any ulterior date mentioned in said notice;
- the last day of the grace period following the non-payment of premium.

Submitting a Claim

A written notice of your claim must be submitted to Assumption Life within 12 months following the date expenses are incurred and must be supported by the required documents. Claim forms may be obtained from the administrator of your group insurance.

Policy Holder Administration (Ontario residents only)

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

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

LIFE INSURANCE

Scope

Provided this coverage is in force upon the death of a participant, the insurer shall pay to the beneficiary the amount of insurance for which the participant was insured as per the Benefit Schedule.

Waiver or Premium

If you become totally disabled and if you remain totally disabled without interruption for the period specified in the summary, the insurer waives collection of any future premiums for this coverage for as long as the total disability continues.

The total disability must be such as to prevent you from performing any gainful occupation for which you are reasonably qualified by training, education and experience.

Your insurance benefit will be the amount insured at the beginning of the total disability. A written request to this effect as well as satisfactory proof of total disability shall be received by the insurer while the total disability persists. This request must be made prior to the expiry of the above-mentioned. The insurer may require further proof on continuing total disability as often as is deemed necessary.

Conversion Privilege

Should you terminate employment before age 65, you have the right to request an individual policy for yourself and/or your spouse without having to provide proof on insurability, provided you apply in writing to Assumption Life and remit the appropriate premium within 31 days following your date of termination.

This conversion privilege is offered in accordance with the rules and regulations of the Superintendents of Insurance.

OPTIONAL LIFE INSURANCE

Eligibility

All employees are eligible for Optional Life Insurance on the effective date of the Group Life Policy in accordance with the terms of the contract.

If Optional Life is requested, an application form accompanied by satisfactory evidence of insurability must be forwarded to the insurer, at the employee's expense.

Effective Date of Insurance

The insurance takes effect on the date the last proof of insurability is accepted by the insurer.

Optional Life Insurance is null and void if the participant, whether sane or insane, commits suicide or dies as a result of an attempted suicide during the first 2 years following the effective date of insurance. The obligation of the insurer then is limited to reimbursing the paid premiums, without interest.

ACCIDENTAL DEATH AND DISMEMBERMENT

Whenever a participant suffers one of the losses described in the summary of benefits, the insurer will pay an indemnity equal to a stated percentage of the amount of insurance. Bodily injury must be caused by external, violent, and accidental means which result in a loss within 365 days. The loss must also result directly from injury and be independent of any other cause.

The following benefits are included:

- Rehabilitation Program
- Spousal Occupational Training Program
- Repatriation
- Education
- Family Transportation
- Home or Vehicle Alteration
- Exposure and Disappearance

FEATURES

1. Benefits are payable over and above the basic amount of life insurance.
2. Provides 24-hour coverage.
3. The maximum benefit payable for any one accident is the principal sum.
4. Waiver of premiums is included according to the terms of the life insurance benefit.

HEALTH CARE INSURANCE

The insurer shall reimburse the insured person the usual, customary and reasonable expenses incurred following a sickness or accident.

Extended Health Benefits

The insurer pays, after subtracting the deductible and in accordance with the percentage indicated to this effect in the Benefit Schedule, the usual, customary and reasonable expenses:

- Expenses incurred for the following services provided upon medical recommendation:
  - the professional services of a **registered nurse** outside a hospital, provided the nurse does not normally reside under the participant's roof or is a member of the family;
  - **laboratory tests** for diagnostic purposes;
  - **blood or plasma transfusions**, the cost of **oxygen** as well as the rental of equipments required for its administration;
  - **X-ray** examinations, except for dental work.

- Expenses incurred under medical prescription:
  - when required, expenses for **ambulance transportation** to or from the nearest hospital providing adequate care, as well as air transportation if the insured person cannot be transported otherwise;
  - the rental purchase, at the discretion of the insurer, of a **non-motorized wheelchair (including repairs), a ventilator, a hospital bed (excluding mattress)** or any other equipment normally designed for use in a hospital for temporary therapeutic purposes;
  - the rental or purchase, at the discretion of the insurer, of **orthopaedic devices or therapeutic equipments**;
  - the cost of corrective devices added on to ordinary shoes or the purchase of an **orthosis or arch support**;
  - the purchase of orthopaedic shoes especially designed for the insured person in a specialized laboratory recognized by the Medical Society;
  - the initial purchase of **artificial eye or limbs**;
  - the purchase of **external breast prosthesis** needed following a mastectomy;
  - cost of necessary supplies related to **colostomy, ileostomy or urostomy**;
  - the purchase of **plaster casts, orthopaedic corsets, trusses, hernial supports, crutches or walkers**;
  - the purchase of **reagent test-sticks, syringes and needles**;
  - the purchase of a **glucometer**;
  - made-to-measure **burn pressure garments** when prescribed by a physician.

- In as much as this coverage is in force on the day treatment is given and subject to prior evaluation by the insurer, **expenses for professional services provided by a dental surgeon** for repairing damages to natural teeth suffered as a result of an accident while the person was insured under this Contract; those services must be rendered within six months of the accident.

However, if the insured person is less than 16 years old, the above-mentioned deadline for treatment does not apply, in as much as the attending dental surgeon informs the insurer of this fact within 90 days of the date of the accident.

Eligible expenses shall be reimbursed as per the benefit summary, as provided for in the current Fee Guide for the use of general practitioners and approved by the Dental Association as well as fees provided in the Fee Guide and approved by the Association of Denturists. These associations are those for the province in which the insured person resides.

- The purchase of **hearing aids**, prescribed by an audiologist.

- Expenses for **paramedical services**:

  These services must be rendered within their specialty and the specialists must be members of their professional association. The specialist must not normally reside under the participant's roof or be a family member. The expenses for paramedical x-rays, if applicable, are included in the paramedical services maximum amount.

- Usual, customary and reasonable expenses in excess of expenses payable by any governmental insurance plan, up to a maximum of $5,000 per insured per accident or sickness, **in case of emergency**, toward general accommodations in an area of hospitalization outside Canada. However, the insured person shall not be entitled to a reimbursement unless the duration of his or her planned absence from Canada **does not exceed 90 consecutive days**. (Only applicable if the insurance contract does not include travel insurance.)

- **Physicians' fees in case of an emergency** which takes place while the insured person is outside his or her home province for a planned period not exceeding 90 consecutive days. Physicians' fees are eligible up to the usual, customary and reasonable rate charged in the area where these expenses have been incurred, less the amount reimbursed by any governmental plan.

- **Intra-uterine devices** prescribed by a physician and obtained from a pharmacist or physician. (In Quebec the intra-uterine devices are reimbursed under the drug plan)

- Reimbursement for the purchase of a **hair prosthesis** following chemotherapy.

- Reimbursement for the purchase of **surgical brassieres** following mastectomy.

- Reimbursement for the purchase of **surgical stockings (varicose vein)**.

Vision Care

The insurer pays the following expenses:

- **Eye examination** by an authorized optometrist.

- Expenses for **eyeglasses** (including frames) or contact lenses prescribed by a physician or optometrist.

- When contact lenses are medically necessary to correct severe astigmatism, severe corneal scarring, keratoconous or aphakia, provided sight cannot be improved to at least the 20/40 level, the maximum eligible expense in any 24 consecutive months is increased to $200.

- Expenses for laser surgery prescribed by a physician or optometrist.

Survivor Benefits

If, at the time of the participant's death, his or her dependents are covered by this coverage, this insurance coverage remains in force without further payment of premiums. Please consult your group plan administrator to confirm the maximum length of the qualifying period.

Second Medical Opinion Services

Any employee or dependent who is covered under this health insurance benefit is entitled to have access to Second Opinion services as of the effective date of this policy, provided that this individual meets the eligibility requirements and that Second Opinion services are available.

Second Opinion works with a Canada-wide network of medical specialists to obtain the best results for the participant. This bilingual service allows the patient to receive a second medical opinion report and benefit from medical coordination services*.

Second Opinion allows participants to receive a second medical opinion report for one of the serious medical conditions covered under the plan through consultation with a Canadian specialist or appropriate U.S. hospital and get medical coordination, including financial discounts whenever possible, for travel to receive medical services in the U.S. or any other country, if required.

Our team offers leading support, uses the best medical practices, and collaborates with the participant's medical practitioners. We leverage our Canadian network of medical specialists to obtain the best medical diagnostic and treatment opinions. When needed, we call upon our worldwide preferred provider organizations, our HMO network in the U.S., and their centers of excellence.

- No age limit
- Service available Monday to Friday, from 8 a.m. to 11 p.m., Eastern Standard Time
- Bilingual service (English and French)
- Wide variety of illnesses and infections covered

Second Opinion:

1. **Locates Canadian medical specialists**
   Online resources are available and a health information specialist can be reached by phone to help identify the medical specialists in the participant's area who are best suited for the specific medical condition.

2. **Communicates which medical treatments are accessible in the Canadian healthcare system**
   Identifies the various programs and treatments available in the participant's area for his or her specific medical condition. The terms and possible risks associated with the treatment options are explained, to help the participant make sound decisions.

3. **Offers a second medical opinion**
   Provides a second medical opinion report for important medical conditions. Second Opinion offers a comprehensive review of the participant's medical file by expert medical consultants across Canada. This review includes:
   - A summary of the clinical history and the questions being asked.
   - A summary of the completed exams.
   - A list of recommendations, for example treatment options and whether further investigations are required. Possible reassurance that case is being managed optimally.

- Appropriate literature references in support of the second opinion.

4. Coordinates medical services*

Upon request, medical coordination services can be provided for the patient to receive medical treatment outside of the province of residence. Novus Health® can coordinate certain aspects related to medical services, such as:

- Arranging medical appointments
- Organizing medical transport
- Purchase of plane or train tickets etc.
- Information regarding passports, visas
- Fee negotiation for a surgery or specific treatment
- Arranging medical appointments

** All fees are payable by and the sole responsibility of the patient.*

Accessing Second Opinion

To access this service, the member or dependant must call Second Opinion at 1-866-735-3169. The member must provide the group insurance policy and certificate number. Our team will then assign an agent to further assist the member or dependant.

Health and Wellness Program

This program provides confidential telephone concierge service as well as a portal that contains evidence-based content and useful tools verified by doctors, pharmacists, and other health professionals.

The Health & Wellness Program helps you navigate the health care system and access valuable and reliable health information. Features include the following:

- Health and wellness resources
- Health screening guide
- Health care guide
- Physician search
- Provincial health services
- Community support groups
- And much more!

You can visit the https://groupinsurancemembers.assumption.ca website anytime, or call 1-866-735- 3169 from 9 a.m. to 12 a.m. (AST), Monday to Friday to speak with one of our health informationspecialists.

Coordination of Benefits

Benefits payable under this coverage are reduced in such a way that, when these benefits are added to benefits provided through any other insurance plan covering these same insurable expenses, then overall benefits do not exceed the true amount of expenses incurred. (Refer to contract for payment sequence.)

Limitations And Exclusions

No benefit is payable for the following expenses:

- expenses that do not comply with usual, customary and reasonable charges of the concerned health profession;
- that part of expenses covered by legislation of Worker's Compensation, hospitalization insurance, health insurance, automobile insurance or any other equivalent law in force in Canada or any other country;
- expenses incurred for examination or treatments for purposes other than curative ones;
- expenses incurred including drugs for a surgery or a treatment of an experimental nature;
- expenses incurred for the purchase of prescribed drugs resulting in a supply corresponding to a period for treatment of more than three months;
- expenses for the adjustment of eye glasses or contact lenses, or the purchase of sun glasses or safety glasses;
- expenses for the purchase of dentures, except for the purchase of the first denture made necessary following an accident which occurs while this coverage is in force;
- expenses for the adjustment or maintenance of hearing aids;
- injuries sustained during a military operation;
- expenses incurred following: self-inflicted injuries, physical or mental damage, while sane or insane; an attempt by the insured person to commit a criminal offence; injuries sustained by the insured person during active participation in a civil commotion, a riot or an insurrection;
- when hospitalized outside of the province, travel benefits may be reduced if a patient does not contact as soon as possible the Assistance Company at the telephone number on his travel insurance card;
- expenses incurred outside of the province while the medical condition of the insured person allowed repatriation, which the insurer required at its own expense but which the insured person refused;
- no benefits are available for insured persons travelling outside their province of residence primarily to seek medical advice or treatment, even if such a trip is on the recommendation of a physician;
- no benefits are available for elective (non-emergency) treatment or surgery, while travelling outside the province of residence, which reasonably could be delayed until the insured person has returned to their province of residence;
- expenses for insulin pumps;
- expenses not specifically indicated in the eligible expenses.

TRAVEL INSURANCE

Insurer pays the usual and customary charges for a semi-private room, physician's services and other covered charges, over and above your Government Insurance Plan, when incurred as a result of unforeseen illness or accidental injury occurring while the participant is traveling outside of the province for a period of **90 consecutive days**. Separate trips with an intervening return to the province of residence of less than 3 days will be considered as one and the same trip for the purpose of this coverage.

The maximum lifetime benefit shall not exceed the equivalent of $2,000,000 in Canada currency per person.

All benefits and limitations mentioned hereafter are expressed in Canadian currency or its equivalent value:

- hospital out-patient services;
- diagnostic X-ray and laboratory test;
- nursing services to a maximum of $3,000;
- transportation expenses; including
    - air or ambulance transportation ;
    - fare to accommodate transportation by stretcher;
    - expenses for return of vehicle up to $750 (whether owned or rented);
    - repatriation expenses for the deceased up to $3,000;
    - board and lodging up to a maximum of $1,050 for costs incurred by a participant or by a companion ($150 per day for 7 days);
    - drugs purchased in case of an emergency requiring the written prescription of a physician or a dentist, in a quantity sufficient for the period of travel only;
    - charges for dental services up to a maximum of $1,000 necessitated as a result of an accident where natural teeth have been damages;
    - the cost of return of dependent children under the age of 16 to their place of residence in Canada to a maximum of $2,000.

Emergency And Payment Assistance

The services of a 24-hour emergency hotline are available to participants who need assistance while travelling. By telephoning the number indicated on your travel insurance card, when a medical emergency occurs, coverage will be confirmed to the hospital or physician. Payment of medical expenses will be arranged or coordinated on behalf of the participant.

Medical Assistance

The patient may call for information on medical facilities and arrangements will be made for:

- advice from a qualified physician;
- medical follow-up of the patient's condition and communication with the subscriber and family;
- return home or transfer of patient if medically permissible;
- transport of a family member to the patient's bedside or to identify the deceased.

Non-Medical Assistance

The patient may call to obtain:

- an emergency response in any major language;
- emergency assistance in contacting the family or business;
- referral to legal counsel.

Coordination of Benefits

Benefits payable under this coverage are reduced in such a way that, when these benefits are added to benefits provided through any other insurance plan covering these same insurable expenses, then overall benefits do not exceed the true amount of expenses incurred. (Refer to contract for payment sequence.)

Limitations

Expenses for treating medical conditions that existed before departure will only be eligible if the condition was stable at the time of departure and no need for medical attention was anticipated for the duration of the trip. A condition will be considered stable by the insurer only if, over the course of the three months preceding the trip, this condition did not:

- require hospitalization;
- result in a relapse or recurrence;
- require any treatment;
- require a change in medication or dosage; or
- reach a terminal phase of evolution.

If an insured person received medical services outside Canada, such services not being available in his province of residence but being available in another Canadian province, coverage is limited to reasonable and customary charges payable for such services in the Canadian location closest to the province of residence of the insured person.

DENTAL CARE

Eligible expenses are based on the current Dental Fee guide in force in the insured person's province of residence.

I Diagnostic

Includes examinations, diagnosis, consultations and necessary X-rays. Panoramic X-rays are provided once in a 36 consecutive month period and supplementary bite-wing X-rays are provided not more than once every six months.

Prevention

Included under this benefit are prophylaxis (teeth cleaning) and application of fluoride solutions.

Oral Surgery

Including extractions and other oral surgical procedures including preoperative and postoperative care.

Minor Restoration

Includes amalgam.

Denture Repairs

Includes relining, rebasing, repair of broken dentures.

Endodontics

Includes pulp therapy and root canal fillings.

Periodontics

Necessary services for detecting and eliminating diseases affecting supporting structure of the teeth.

Coordination of Benefits

Benefits payable under this coverage are reduced in such a way that, when these benefits are added to benefits provided through any other insurance plan covering these same insurable expenses, the overall benefits do not exceed the true amount of expenses incurred.

Limitations And Exclusions

No benefit is payable for the following expenses:

- Expenses in excess of the usual, customary and reasonable charges for the least expensive dental care;
- Expenses covered by legislation, a government plan or any other group insurance coverage;
- Expenses incurred for treatments which are for cosmetic purposes or for purposes other than curative ones;
- Expenses incurred for surgery or treatment of an experimental nature;
- Expenses incurred for replacing lost, stolen or mislaid dentures;
- Fees charged for a missed appointment or for completion of an insurance form;
- Expenses incurred following self-inflicted, injuries sustained during a military operation, injuries sustained by the insured person during active participation in a civil commotion, a riot or an insurrection;
- Expenses for initial insertion of a complete or partial removable denture, if the prosthesis serves to replace one or more natural teeth removed before the effective date of this contract;
- Expenses incurred for nutritional counseling, recommendations, oral hygiene instructions, dental plaque control programs and corrective treatments related to congenital or progressive malformation;
- Expenses relating to implant dentistry. Including x-rays, bone grafts, sinus lift and related implant work.
- Fees for dental treatment rendered for full mouth reconstructions, for vertical dimension correction or for the correction of temporomandibular joint dysfunction;
- Fees relating to orthodontic treatments including the correction of malocclusion;
- Expenses not specifically indicated in the eligible expenses.

Survivor Benefits

If, at the time of the participant's death, his or her dependents are covered by this coverage, this insurance coverage remains in force without further payment of premiums. Please consult your group plan administrator to confirm the maximum length of the qualifying period.