Randstad Advantage

Extended Health and Dental – Basic Plan

Policy Number: 17879

Effective: November 1, 2023

The following certificate wording is provided solely for your convenience and reference. It is incomplete and does not include the Policy Particulars page. We periodically make changes to certificate wording and therefore this incomplete sample may not duplicate the wording of any actual issued certificate. It is not to be construed or interpreted in any manner as a contract or an offer to contract. The actual certificate issued to any given member will govern that relationship.

The information in this policy is important to you. It provides the information you need about the benefits available through your contract with Canadian Premier Life Insurance Company (Securian Canada).

Securian Canada is the brand name used by Canadian Premier Life Insurance Company and Canadian Premier General Insurance Company to do business in Canada. Benefits are underwritten by Canadian Premier Life Insurance Company.

Canadian Premier Life Insurance Company (Securian Canada) agrees to provide the benefits of this policy according to its terms and conditions.

Securian Canada is the brand name used by Canadian Premier Life Insurance Company and Canadian Premier General Insurance Company to do business in Canada.

Signed at Toronto, Ontario

Nigel Branker
Chief Executive Officer

Deliska Beauregard
Chief Legal Officer & Corporate Secretary

THIS DOCUMENT CONTAINS IMPORTANT INFORMATION ABOUT YOUR INSURANCE.

PLEASE KEEP IT IN A SAFE PLACE.

Questions? We're here to help. Talk to Securian Canada's Customer Care representative for assistance with your coverage by calling toll-free at 1-877-363-2773 or visit our website at *www.securiancanada.ca*.

In this document, *you* and *your* mean the owner of this policy. *We*, *us*, *our*, and *the company* mean Securian Canada.

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Plan summary

Basic plan summary with dental coverage

Benefit	Reimbursement	Maximum per person
Drug	60%	$750 of eligible expenses per calendar year
Extended health	60%	Described in the *Extended health* section
Preventive dental	60%	$500 per calendar year

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

Drug

The amount we pay for the dispensing fee reimbursement is 100% but is limited to a maximum of $5 per prescription.

For Québec residents only:

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

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

Waiting periods

Dental
An insured person becomes eligible for the preventive dental benefit 90 days after the effective date of this policy.

Definitions

Acupuncturist	a person who is listed on the appropriate provincial registry.
Calendar year	January 1 to December 31.
Chiropodist/Podiatrist	a person licensed by the appropriate provincial licensing authority to practice.
Chiropractor	a member of the Canadian Chiropractic Association or of a provincial association affiliated with it.
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 licensing authority.
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.

Naturopath	a member of the Canadian Naturopathic Association or any provincial association affiliated with it.
Nurse	an out-of-hospital private duty nurse, when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse who is licensed, certified or registered in the province where the insured person lives and who does not normally live with the insured person and includes a registered nurse (RN), registered nursing assistant (RNA), certified nursing assistant (CNA), licensed practical nurse (LPN) or a registered practical nurse (RPN).
Osteopath	a person who holds the degree of doctor of osteopathic medicine from a college of osteopathic medicine approved by the Canadian Osteopathic Association.
Paradental practitioner	a person licensed by the appropriate provincial authority to work as a practitioner fitting dentures for, and supplying dentures directly to, the public.
Physician	a doctor of medicine (M.D.) licensed to practice medicine.
Physiotherapist	a member of the Canadian Physiotherapy Association or of a provincial association affiliated with it.
Policy anniversary	the month and day every year that is the same date as your policy date.
Psychologist	a certified psychologist who is listed on the appropriate provincial registry in the province in which the service is rendered.
Reasonable and customary charges	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. for dental procedures: ▪ charges considered necessary for the treatment and maintenance of a person's oral health, according to standard Canadian dental procedures and practices, and ▪ charges of a reasonable frequency and duration, as determined by us..
Registered massage therapist	a person licensed by the appropriate provincial licensing body to practice massage therapy, or in the absence of a provincial licensing body, a person whose qualifications meet those required by a licensing body to practice massage therapy.
Registered pharmacist	a person who is licensed to practice pharmacology and whose name is listed on the pharmacists' registry of the licensing body for the jurisdiction in which such person is practising.
Speech language pathologist	a person who holds a Master's degree in speech language pathology and is a member or is qualified to be a member of the Canadian Speech and Hearing Association or any provincial association affiliated with it.

General provisions

The Policy

This policy, which includes the application, the *Policy particulars* page and any amendment agreed to in writing, may not be changed or any provisions waived unless agreed to in writing by our officers authorized to sign policies.

The currency of this policy is Canadian.

If you or another insured person fail to tell us every fact material to the insurance, or misrepresent those facts, we may void the insurance.

Statements made on the application or on an evidence of insurability form, which are fraudulent, or a misstatement of age, may be contested at any time. Other statements are incontestable two years after the statements are made.

If you change your mind within 30 days

You may send us a written request to cancel your policy within:

- 30 days of receiving it from us, or
- 60 days after the policy is issued, whichever date is earlier.

When we receive your written request we'll refund any amount paid. This is called rescission.

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

Your decision to cancel your policy is your personal right. The cancellation is binding on you and any beneficiaries you have named, whether the beneficiaries are revocable or irrevocable.

All of our obligations and liabilities under this policy will end immediately when we receive your request to cancel it.

To cancel your policy, contact our Customer Care centre, toll-free at 1-877-363-2773.

Premiums

The premium is determined according to the age of each insured person and the province where they live. If a change in age puts the insured person into another rate category, premiums are adjusted at the next policy anniversary. If an insured person changes the province where they live, premiums are adjusted according to the rates of the new province of residence and are effective on the date of the change.

We have the right to change your premium. We will give you 30 days written notice before the change is made.

Grace period

The grace period is 31 days for the payment of premiums 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.

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 health insurance,
  - Québec 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:
  - legally married to you or in a civil union,
  - living with you in a conjugal relationship and represented as your spouse or partner, or
  - a child born to you, adopted by you, or a step child, who is unmarried and entirely dependent on you for maintenance and support and who is also:
    i) under 21 years of age, or
    ii) under 25 years of age and attending a college or university full time, or
    iii) physically or mentally incapable of self-support and became incapable of self-support while entirely dependent on you while eligible under i) or ii).

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

Changes

Changing plan type

You may apply at any time to change your existing plan type (basic, standard or enhanced) to any other plan type we offer at the time you apply for the change. You must apply in writing. We will require new evidence of insurability from all insured persons. If your application is approved, the change to your plan type takes effect on the date we determine.

Adding an insured person

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.

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.

You may apply to add any child who is unmarried and entirely dependent on you for maintenance and support and is either born to you, adopted by you, or is a stepchild and is:

i) under 21 years of age, or

ii) under 25 and attending college or university full time, or

iii) physically or mentally incapable of self-support and became incapable of self-support while entirely dependent on you for maintenance and support while eligible under i) or ii).

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.

Your right to cancel this policy

You may cancel this policy at any time by sending a written request to the address shown at the beginning of the policy. We must receive a minimum of ten days advance written notice of termination.

Claims

We must receive your claim within 365 days of the date 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 **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 a claim. You must pay any additional cost associated with providing this information.

After your policy ends

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

Payment of claims

We will pay claims 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 will pay

We confirm all expenses you submit are eligible expenses. We determine if there are any limitations 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 reasonable and 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.

Legal Actions

Limitation period for insureds residing in 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 insureds residing outside of 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 *Insurance Act* or other applicable legislation of your province or territory.

Recovering payments from a third party (Subrogation)

If we have made a payment 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 have paid. Our right of reimbursement will apply to any full or partial payments you are entitled to or may receive.

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 the 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.

General exclusions

We will not pay for expenses:

- incurred, directly or indirectly caused by or associated with civil disorder or war, whether declared or not; or service in the naval, military or air force of any country, combination of countries or international organization at war, whether war is declared or not,
- 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 unless explicitly listed as covered under this benefit,
- for services or supplies that are not approved by Health Canada or other government regulatory body for the general public,
- for services or supplies that are not generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards,
- for services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada), and
- for elective (non-emergency) medical treatment or surgery which is received or performed out of province where they live.

Assignments

We reserve the right to deny your request for an assignment.

Drugs

Covered drugs and drug supplies

- drugs and oral contraceptives that must be prescribed and are identified in the Monographs section of the current Compendium of Pharmaceuticals and Specialties as a narcotic, controlled drug, or requiring a prescription,
- life-sustaining drugs that may not require a prescription and are identified in the Therapeutic Guide section of the current Compendium of Pharmaceuticals and Specialties under the following headings:
  - anti-anginal agents
  - antiparkinsonism agents
  - bronchodilators
  - antihyperlipidemic agents
  - hyperthyroidism therapy
  - parasympathomimetic agents
  - tuberculosis therapy
  - anticholinergic preparations
  - anti-arrhythmic agents
  - glaucoma therapy
  - insulin preparations
  - oral fibrinolytic agents
  - potassium replacement therapy
  - topical enzymatic debriding agents
- injectible drugs,
- compounded prescriptions where one of the ingredients is an eligible covered drug,
- needles, syringes, and chemical diagnostic aids for the treatment of diabetes, and
- aids to help a person quit smoking that require a prescription and are limited to a maximum of $250 lifetime.

The maximum amount we will pay for any single purchase is limited to the cost of any eligible drugs or drug supplies that can reasonably be used in a 100 day period.

Eligibility criteria for drugs and drug supplies

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

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

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

Other health professionals allowed to prescribe drugs – We reimburse certain drugs prescribed by other qualified health professionals the same way as if the drugs were prescribed by a doctor or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

Drug substitution limit: 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, even when prescribed:

- drugs used for the treatment of infertility,
- drugs for the treatment of erectile dysfunction,
- drugs used for the treatment of obesity,
- dietary supplements, vitamins and infant foods,
- the cost of giving injections, serums and vaccines,
- contraceptives (other than oral),
- over-the-counter products designed to help a person quit smoking, and
- expenses incurred under any of the conditions specified in the *General exclusions* section of the *General provisions* pages.

Extended health

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.

Reference to physician may also include a nurse practitioner – If the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services, Securian Canada 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. For drugs, refer to *Other health professionals allowed to prescribe drugs*.

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

We will pay for the services of the practitioners listed below. The service must be performed within the practitioner's area of expertise and require the skills and qualifications of that practitioner. All maximum amounts set out in this provision apply to each insured person.

Prescription required for the services of a:

- acupuncturist,
- physiotherapist,
- psychologist,
- registered massage therapist, or
- speech language pathologist.

Prescription not required for the services of a:

- chiropractor, including one x-ray examination in a calendar year,
- naturopath,
- osteopath, including one x-ray examination in a calendar year, or
- podiatrist or chiropodist, including one x-ray examination in a calendar year.

The amount we pay is limited to $25 per visit and calendar year maximum of $250 for each practitioner.

For the services of a chiropractor, podiatrist and chiropodist, we will reimburse expenses before you exceed the annual maximums under the provincial 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 365 days 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 emergency air 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. If the insured person requires the services of a registered nurse during the flight, we will pay for their services and their return air fare. We will pay when we receive proof that the insured person has applied for the applicable government funding for this service.

We will pay for hearing aids and repairs to them, excluding batteries, limited to $400 during in any 60 month period. The 60 month 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,
- services of a nurse provided in the insured person's home. The insured person's treatment must require the level of expertise of a nurse,
- walkers, 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:

- blood glucose monitors, limited to $150 in any 60 month period,
- diagnostic laboratory and x-ray examinations,
- elastic support stockings, including pressure gradient hose, when prescribed by a physician,

- 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 a combined maximum of $150 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,
- 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 in a calendar year, and
- repairs to durable medical equipment we cover under this policy will be reimbursed up to the percentage indicated on the *Plan summary* page.

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

For Quebec residents only, we will pay for magnetic resonance imaging (MRI), computerized axial tomography (CAT) and computerized tomography (CT) scans, and ultrasounds to a combined maximum of $750 in a calendar year.

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,
- utilization fees which are imposed by the provincial health care plan for the use of a service, and
- expenses incurred under any of the conditions specified in the *General exclusions* section of the *General provisions* pages.

Dental

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 before you incur the expense to confirm whether an expense is eligible. We may deny a claim if we have not confirmed 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 and customary charges will be covered if they are:

- up to the reasonable and customary 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 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 reasonable and customary 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.

Getting an estimate before you have certain procedures

For any major treatment or any procedure that will cost more than $500, we suggest that you send us an estimate before the work is done. Here's what to expect:

- you will send us a completed dental claim form that shows the treatment that the dentist is planning and the cost.
- both you and the dentist will have to complete parts of the claim form.
- we will tell you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.

What is covered

The following dental procedures are considered eligible expenses.

Preventive dental procedures

- oral examinations:
  - one complete examination every 60 months,
  - one recall examination every 8 months,
  - emergency or specific examinations,
- x-rays:
  - one complete series of x-rays or one panoramic x-ray every 60 months,
  - 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 8 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 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,
- full mouth reconstructions for vertical dimension correction or for correction of temporomandibular joint dysfunction,
- expenses incurred for the treatment of malocclusion or for orthodontic treatment,
- services rendered in conjunction with surgical services payable under a government plan,
- 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 *General exclusions* section of the *General provisions* pages.

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,

      i. 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

      ii. 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 their 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.

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We're here for all Canadians and their families – however they define family – because everything we do helps build secure tomorrows. Our practical, life-ready insurance and protection solutions are designed to help provide financial security, so that Canadians can spend more time making every moment count.

For over 65 years, we've been giving Canadians the confidence to face life's uncertainties. Securian Canada brings together strong local roots and expertise, a North American footprint, and a global perspective – all while innovating at the speed the markets we serve expect.

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