Randstad Affiliation Plan

Extended Health Care and Dental Insurance Policy

Enhanced plan

Sun Life Financial

Sun Life Assurance Company of Canada agrees with you, the policy owner, to pay 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, a member of the Sun Life Financial group of companies.

Signed at Toronto, Ontario

Dean Connor
President and Chief Executive Officer
Sun Life Assurance Company of Canada

Dana Easthope
Vice-President, Associate General Counsel and Corporate Secretary
Sun Life Assurance Company of Canada

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Your out of province insurance coverage is designed to cover losses arising from sudden and unforeseeable circumstances. It is important that you read and understand your policy before you travel as your coverage may be subject to certain limitations or exclusions.

A pre-existing condition may apply to medical conditions and/or symptoms that existed prior to your trip. Check to see how this applies in your policy and how it relates to your departure date, date of purchase or effective date.

In the event of an accident, injury or sickness, your prior medical history may be reviewed when a claim is reported.

If you require travel assistance, you may be required to notify the designated assistance company prior to treatment. Your policy may limit benefits should you not contact the assistance company within a specified time period.

Please read your policy carefully before you travel.

If you change your mind, you may send us a written request to cancel your policy within 30 days of receiving it and we will refund any amount paid to us.

If you have any questions or require more information, please contact us at:

Sun Life Assurance Company of Canada
225 King St. W.
7th Floor
Toronto, ON M5V 3C5
1 800 669 7921

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Enhanced plan summary with dental and semi-private hospital room coverage

Benefit	Reimbursement	Maximum per person
Enhanced drug	80% on first $5,000 100% on next $95,000	$100,000 of eligible expenses in a calendar year
Extended health	100%	Described in the *Extended health provision*
Vision	100%	$200 every two calendar years
Emergency travel medical coverage	100%	60 days per trip $1,000,000 lifetime
Semi-private hospital room	85%	Described in the *Semi-private hospital room provision*
Preventive dental	80%	$750 in a calendar year
Restorative dental	50%	$500 in a calendar year
Orthodontic	60%	$1,500 lifetime

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

Waiting periods
Vision
An insured person becomes eligible for the vision benefit one year after the effective date of this policy.

Dental
An insured person becomes eligible for:
- the preventive dental benefit three months after the effective date of this policy,
- the restorative dental benefit one year after the effective date of this policy, and
- the orthodontic benefit two years after the effective date of this policy.

Dental benefit - anaesthesia and laboratory charges
When an insured person incurs anaesthesia and laboratory charges, these charges will only be reimbursed if incurred while receiving eligible dental services. The reimbursement for the anaesthesia and laboratory charges is limited to the reimbursement percentage of the services they were performed with.

General provisions

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 insurabililty	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).
Ophthalmologist	a person licensed to practice ophthalmology.
Optometrist	a member of the Canadian Association of Optometrists or of a provincial association associated with it.

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 *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.
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.

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.

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,
    - 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:
    - 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 12 months 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 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 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'll 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 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.

Time limit for recovery of insurance money

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 Insurance Act or the provincial or territorial legislation that applies to this policy.

Recovering payments from a third party (Subrogation)

If we've 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've 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.

We will also not pay for intentionally self-inflicted injuries, while sane or insane.

Enhanced drug provision

Covered drugs and drug supplies

- drugs 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 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 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.

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, 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 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.

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.

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 $400 in a calendar year 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 12 months 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 $500 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 *when we receive proof* that the insured person has applied for the applicable government funding for the 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, limited to a calendar year maximum of $10,000 and a lifetime maximum of $30,000.

We will pay for the following provincially funded services and equipment, limited to a combined calendar year maximum of $5,000.

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. Breast prosthesis are limited to $200 in a calendar year,
- braces, provided they are not solely for athletic use,
- oxygen,
- walkers, if we have approved either its purchase or rental,
- wheel chair limited to a lifetime maximum of $4,000, 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 $300 per each five year period,
- diagnostic laboratory 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,
- hospital bed, limited to a lifetime maximum of $1,500,
- 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 limited to $500 in a calendar year,
- wigs and hairpieces required as a result of alopecia, chemotherapy, or radiation therapy, limited to a lifetime maximum of $500, 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.

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.

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 *General exclusions* section of the *General provisions* pages.

Emergency travel medical coverage

Eligible expenses
We will cover eligible expenses up to the limit specified on the *Plan summary* page and those described below.

Hospital and medical services and travel assistance expenses must satisfy all of the following criteria to be eligible. They must be:

- medically necessary,
- incurred due to an emergency which occurs during the first 60 days of travelling outside the province in which the insured person lives. The 60-day travel period starts on the first day of departure from the province where the insured person lives,
- incurred as a result of emergency treatment of an illness or injury which occurs outside the province in which the insured person lives, and
- for an insured person who is under the age of 80. This coverage ends on the insured person's 80th birthday.

Emergency services covered under the emergency travel medical coverage include any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery required as the result of an emergency.

Whether or not a claim has been made, if the insured person is under age 65 they must return to the province where they live for 24 hours before becoming eligible for another 60 days of coverage.

Whether or not a claim has been made, if the insured person is age 65 or older they must return to the province where they live for 20 days before becoming eligible for another 60 days of coverage.

Travel assistance services
We will provide a toll-free number which gives insured persons 24-hour access to a worldwide assistance network. For an emergency which occurs during the 60-day travel period, the network will provide the following emergency assistance services:

- physician and hospital referrals,
- ongoing monitoring of medical treatment if an insured person is hospitalized,
- coordination of transportation arrangements via ground or air ambulance if it is medically necessary to return an insured person to Canada or transfer them to another hospital that is equipped to provide the required treatment,
- payment assistance for hospital and medical expenses,
- legal referrals,
- a telephone interpretation service, and
- a message service for insured persons; messages will be held up to 15 days.

Emergency payment assistance
You must confirm your provincial health care coverage and coverage under the health provisions of this policy with our emergency assistance provider before receiving medically necessary services to ensure that any expenses you incur are paid. If you are not able to confirm with our emergency travel assistance provider before receiving services, you must do so as soon as is reasonably possible afterward. If you don't confirm coverage and services are received in circumstances where you could have reasonably contacted our emergency assistance provider, then we have the right to deny or limit payments for all expenses not confirmed. If we've paid for hospital and medical expenses on behalf of an insured person, you must sign an authorization form allowing us to recover the amount we've paid from the appropriate provincial health care plan.

If we've paid or have agreed to pay for expenses that require a portion to be paid by the insured person under this policy or the provincial health care plan, or are not covered under this policy, you must reimburse us for any amount payable by the insured person or not covered under these policies.

If we haven't paid for expenses incurred, we will only reimburse you when we receive proof satisfactory to us of your claim for reimbursement.

Hospital and medical services
We cover reasonable and customary charges for the following items, less the amount payable by a provincial health care plan:

- public ward accommodation and auxiliary hospital services in a general hospital,
- services of a physician,
- economy air fare to return the insured person to the province where they live for medical treatment,
- licensed ground ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada as determined by us or our emergency travel assistance provider,
- emergency air ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada as determined by us or our emergency travel assistance provider, when the insured person's physical condition prevents the use of another means of transportation, and
- the services and return air fare for a registered nurse when the insured person's physical condition prevents the use of another means of transportation, and the insured person requires a registered nurse during the flight.

The maximum lifetime amount we will pay for hospital and medical services is $1,000,000 for each insured person.

Expenses that are included as eligible expenses under other health benefits in this policy are also eligible while travelling outside Canada. These expenses are subject to the reimbursement percentages listed under the appropriate benefit in the *Plan summary*.

Travel assistance benefits
We cover reasonable and customary charges for the following family assistance benefits:

- return transportation for an insured person who is under age 16, or is handicapped, and they are left unattended because you or an insured person is hospitalized outside the province where you live. We will provide an escort to accompany them, if we or our emergency travel assistance provider determine it's necessary. The maximum payable for the return transportation is a one-way economy fare for each insured dependant who is under age 16, or who is handicapped,
- return transportation of any insured person, if their hospitalization or another insured person's hospitalization prevents them from returning home on the originally scheduled, pre-paid transportation, and they must purchase new return tickets. The extra cost of each return fare is payable to a maximum of a one-way economy fare, less any amount reimbursed for the unused return tickets,
- a visit of a spouse, parent, child, brother or sister, of the insured person when that insured person is hospitalized for more than seven days while travelling without a relative. The visit includes meals and accommodation up to a maximum of $150 per day, and round-trip economy transportation, for the person visiting. These expenses are also covered when it is necessary for one of them to identify a deceased insured person before the release of their body, and
- meals and accommodation up to a maximum of $150 per day (in total, not per person), if another insured person's trip is extended because an insured person is hospitalized.

The combined maximum amount we will pay for family assistance benefits is $5,000 for each travel emergency.

Repatriation
If an insured person dies while outside of the province where they lived, we will arrange for the necessary authorizations and the return of the deceased to the province where they last lived. Preparation of the deceased for repatriation includes expenses for cremation at the place of death. Return of the deceased includes a basic shipping container, but excludes expenses for burial, such as burial caskets and urns.

The maximum amount we will pay for the preparation and return of the deceased is $5,000.

Vehicle return
If an insured person is unable to operate a vehicle (owned or rented) because they are being returned to Canada for medical treatment, we will pay the cost of returning the vehicle to the province where they live, or the nearest appropriate rental agency. We will also pay this benefit when the insured person dies.

The maximum amount we will pay for returning the vehicle is $1,000.

Exclusions and limitations

At the time of an emergency, the insured person or someone present with the insured person must contact our emergency travel assistance provider. All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by our emergency travel assistance provider before being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to a hospital.

If you are not able to contact our emergency travel assistance provider before receiving services, you or someone present with the insured person must do so as soon as is reasonably possible afterward. If you don't contact our emergency travel assistance provider and emergency services are received in circumstances where you could have reasonably contacted our emergency assistance provided, then we have the right to deny or limit payments for all expenses related to that emergency.

An emergency ends when the insured person is medically stable to return to the province where they live.

We will not pay the expenses:

- for services that are not immediately required or which could reasonably be delayed until the insured person returns to the province where they live,
- for services relating to an illness or injury which caused the emergency, if they were received after the emergency ended,
- for services provided to the insured after the date that we or our emergency travel assistance provider, based on available medical evidence, determine that the insured person can be returned to the province where they live,
- for services received by the insured person for an illness or injury, including any complications if the insured person unreasonably refused or neglected to receive recommended medical services for that illness or injury,
- for services related to an illness or injury, including any complications or any emergency arising directly or indirectly from that illness or injury, where the trip was taken to obtain medical services for that illness or injury,
- incurred by an insured person for an emergency which occurs more than 60 days after departure from the province where they live,
- for the regular treatment of a chronic injury or illness. Emergency services do not include treatment provided as part of an established management program that existed before the insured person left their province of residence,
- due to or related to a pre-existing medical condition. A "pre-existing" medical condition is one where symptoms appeared or required medical attention, hospitalization or treatment (including changes in medication or dosage) during the nine-month period before the insured person's departure from the province where they live,
- due to pregnancy and incurred within four weeks of the insured person's expected date of delivery,
- for a child born outside of Canada until the later of their coverage effective date, or the date the child returns to Canada,
- incurred on a non-emergency or referral basis, and
- incurred under any of the conditions specified in the *General exclusions* section of the *General provisions* pages.

To determine eligibility, we may require the attending physician to provide medical evidence certifying that the insured person's medical condition was stable for a minimum period of nine months before the insured person traveled outside the province where they live. "Stable" means that the attending physician has stated that he does not expect a recurrence of the same medical condition or any problems related to that condition while the insured person travels outside the province where they live.

Due to conditions such as war, political unrest, epidemics, and geographic inaccessibility, emergency assistance services may not be available in certain countries.

Neither we nor the emergency travel assistance provider providing the assistance services is responsible for the availability, quality or results of the medical treatment received by the insured person, or for the failure to obtain medical treatment.

Semi-private hospital room coverage

Eligible expenses
We will cover eligible expenses based on the reimbursement percentage specified on the *Plan summary* page.

Eligible expenses mean the reasonable and customary charges for semi-private accommodation in a hospital limited to $200 per day up 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. If accommodation is in a convalescent hospital, we will pay $20 per day up to 180 days for hospital admission due to the same or related cause.

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 rentals, and
- expenses incurred under any of the conditions specified in the *General exclusions* section of the *General provisions* 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 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 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 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, except for orthodontic procedures where an expense is incurred for each appointment.

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 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).

Restorative dental procedures

- endodontics, such as root canal therapy, root canal fillings, and treatment of disease of the pulp tissue,
- periodontics – the treatment of disease of the gum and other supporting tissue,
- occlusal adjustment, also described as equilibration (not to exceed four time units per year),
- periodontal appliances (once every five years),
  - appliance maintenance (once every six months),
  - appliance reline,
  - post treatment evaluation,
- onlay restorations,
- crowns and repairs to crowns, other than prefabricated metal restorations,
- partial and complete dentures and repairs or additions to them,
- rebase or reline of a partial or complete denture,
- fixed bridgework and repairs to them,
- surgical services limited to:
  - alveoplasty,
  - dislocations,
  - enucleation of cysts,
  - frenectomy,
  - lacerations,
  - miscellaneous surgical services,
  - surgical extractions and repositioning (surgery requires surgical flap or sectioning of the tooth),
  - surgical excision,
- anaesthesia (if performed in conjunction with oral surgery),
  - conscious sedation,
  - deep sedation,
  - general anaesthesia, and
- drug injections.

Orthodontic procedures

- interceptive, interventive or preventive orthodontic services, other than space maintainers, and
- comprehensive orthodontic treatment, using a removable or fixed appliance, or combination of both. This includes diagnostic procedures, formal treatment and retention.

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.

The amount payable for an eligible restorative crown on a molar is limited to the fee charged for a metal restorative crown.

To determine the extent of damage to a crown or onlay, we will require the insured person or their dentist to submit x-rays and study models.

Replacement of an existing denture, bridgework, crown or onlay is an eligible expense if the replacement is required to replace an existing denture, bridgework, crown or onlay that was installed at least eight years before the replacement. We determine the maximum eligible expense based on the value and quality of the original denture, bridgework, crown or onlay.

The addition of teeth to an existing partial denture or bridgework is an eligible expense if the addition is required to replace one or more teeth removed while the insured person is insured under this policy.

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,
- services rendered in conjunction with surgical services payable under a government plan,
- crowns and onlays placed on a tooth not functionally impaired by incisal angle or cuspal damage,
- prosthetic devices which are ordered while an insured person is insured under this policy, but are installed after termination of this optional dental provision,
- initial dentures, bridgework or crowns to replace a tooth or teeth missing before becoming insured under this policy or to replace a tooth or teeth congenitally missing,
- replacement of dentures, crowns, onlays or bridgework and addition of teeth to existing dentures, crowns, onlays or bridgework except as provided above,
- replacement dentures which have been lost, stolen or misplaced,
- permanent splinting,
- full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
- replacement of orthodontic appliances which have been lost, stolen or misplaced,
- implants and transplants, and repositioning of the jaw,
- 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.

Appendix – Statutory conditions

The Policy

The application, the Policy particulars page, this policy and any amendment to the policy agreed upon in writing after this policy is issued, constitute the entire policy, and no agent has authority to change the policy or waive any of its provisions.

Waiver

We are deemed not to have waived any condition of this policy, either in whole or in part, unless our waiver is clearly expressed in writing signed by our authorized signing officers.

Copy of application

We will on your request, give you a copy of the application for this policy.

Material facts

No statement made by an insured person at the time of application for this policy can be used in defense of a claim under or to avoid this policy unless it is in the application or any other written statements or answers given as evidence of insurability.

Termination by us

We may terminate this policy at any time by giving written notice of termination to you and by refunding concurrently with the notice, the amount of premium paid in excess of the proportional premium for the expired time. The written notice may be delivered to you or sent by registered mail to the last address we have recorded for you in our records.

Termination of insurance
We may terminate your policy by giving you 15 days written notice by registered mail.

Termination for non-payment
If the initial premium has not been fully paid when due, we may terminate your policy by giving you 15 days written notice by registered mail.

The 15 days notice of termination by registered mail starts on the day the registered letter or notification of it is delivered to your postal address.

Notice and proof of claim

You must send us written notice of all claims not later than the time period set out in your policy for making a claim by sending claims either by regular mail to us or electronically, where available.

You must give us any proof we consider is reasonably necessary for a claim.

Failure to give notice or proof

Failure to give notice of claim or provide proof of a claim within the time limit set out in this statutory condition does not invalidate the claim if you give notice or proof as soon as is reasonably possible and in no event later than12 months from the date that an eligible expense is incurred.

When money is payable

All money payable under this policy shall be paid by us within 60 days after we receive satisfactory proof of claim.

Insurer to furnish forms for proof of claim

We shall furnish forms for proof of claim within 15 days after receiving notice of claim, but where 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 giving rise to the claim.

Randstad Affiliation Plan Extended Health Care and Dental Insurance Policy

Enhanced plan

Quebec

Sun Life Financial

Sun Life Assurance Company of Canada agrees with you, the policy owner, to pay 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, a member of the Sun Life Financial group of companies.

Signed at Toronto, Ontario

Dean Connor
President and Chief Executive Officer
Sun Life Assurance Company of Canada

Dana Easthope
Vice-President, Associate General Counsel and Corporate Secretary
Sun Life Assurance Company of Canada

IMPORTANT NOTICE – PLEASE READ CAREFULLY

Your out of province insurance coverage is designed to cover losses arising from sudden and unforeseeable circumstances. It is important that you read and understand your policy before you travel as your coverage may be subject to certain limitations or exclusions.

A pre-existing condition may apply to medical conditions and/or symptoms that existed prior to your trip. Check to see how this applies in your policy and how it relates to your departure date, date of purchase or effective date.

In the event of an accident, injury or sickness, your prior medical history may be reviewed when a claim is reported.

If you require travel assistance, you may be required to notify the designated assistance company prior to treatment. Your policy may limit benefits should you not contact the assistance company within a specified time period.

Please read your policy carefully before you travel.

If you change your mind, you may send us a written request to cancel your policy within 30 days of receiving it and we will refund any amount paid to us. If you have any questions or require more information, please contact us at:

Sun Life Assurance Company of Canada
225 King St. W.
7th Floor
Toronto, ON M5V 3C5
1 800 669 7921

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Enhanced plan summary with dental and semi-private hospital room coverage - Quebec

Benefit	Reimbursement	Maximum per person
Enhanced drug	80% on first $5,000 100% on next $95,000	$100,000 of eligible expenses in a calendar year
Extended health	100%	Described in the *Extended health provision*
Vision	100%	$200 every two calendar years
Emergency travel medical coverage	100%	60 days per trip $1,000,000 lifetime
Semi-private hospital room	85%	Described in the *Semi-private hospital room provision*
Preventive dental	80%	$750 per calendar year
Restorative dental	50%	$500 per calendar year
Orthodontic	60%	$1,500 lifetime

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

Enhanced drug
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
Vision
An insured person becomes eligible for the vision benefit one year after the effective date of this policy.

Dental
An insured person becomes eligible for:
- the preventive dental benefit three months after the effective date of this policy,
- the restorative dental benefit one year after the effective date of this policy, and
- the orthodontic benefit two years after the effective date of this policy.

Dental benefit - anaesthesia and laboratory charges
When an insured person incurs anaesthesia and laboratory charges, these charges will only be reimbursed if incurred while receiving eligible dental services. The reimbursement for the anaesthesia and laboratory charges is limited to the reimbursement percentage of the services they were performed with.

General provisions

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 insurabililty	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).
Ophthalmologist	a person licensed to practice ophthalmology.
Optometrist	a member of the Canadian Association of Optometrists or of a provincial association associated with it.

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 *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.
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.

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.

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,
    - 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:
    - 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 12 months 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 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 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'll 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 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.

Recovering payments from a third party (Subrogation)

If we've 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've 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.

We will also not pay for intentionally self-inflicted injuries, while sane or insane.

Enhanced drug provision

Covered drugs and drug supplies

- drugs 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 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 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.

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, 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 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.

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.

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 $400 in a calendar year 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 12 months 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 $500 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 *when we receive proof* that the insured person has applied for the applicable government funding for the 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, limited to a calendar year maximum of $10,000 and a lifetime maximum of $30,000.

We will pay for the following provincially funded services and equipment, limited to a combined calendar year maximum of $5,000.

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. Breast prosthesis are limited to $200 in a calendar year,
- braces, provided they are not solely for athletic use,
- oxygen,
- walkers, if we have approved either its purchase or rental,
- wheel chair limited to a lifetime maximum of $4,000, 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 $300 per each five year period,
- diagnostic laboratory 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,
- hospital bed, limited to a lifetime maximum of $1,500,
- 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 limited to $500 in a calendar year,
- wigs and hairpieces required as a result of alopecia, chemotherapy, or radiation therapy, limited to a lifetime maximum of $500, 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.

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.

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 *General exclusions* section of the *General provisions* pages.

Emergency travel medical coverage

Eligible expenses
We will cover eligible expenses up to the limit specified on the *Plan summary* page and those described below.

Hospital and medical services and travel assistance expenses must satisfy all of the following criteria to be eligible. They must be:

- medically necessary,
- incurred due to an emergency which occurs during the first 60 days of travelling outside the province in which the insured person lives. The 60-day travel period starts on the first day of departure from the province where the insured person lives,
- incurred as a result of emergency treatment of an illness or injury which occurs outside the province in which the insured person lives, and
- for an insured person who is under the age of 80. This coverage ends on the insured person's 80th birthday.

Emergency services covered under the emergency travel medical coverage include any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery required as the result of an emergency.

Whether or not a claim has been made, if the insured person is under age 65 they must return to the province where they live for 24 hours before becoming eligible for another 60 days of coverage.

Whether or not a claim has been made, if the insured person is age 65 or older they must return to the province where they live for 20 days before becoming eligible for another 60 days of coverage.

Travel assistance services
We will provide a toll-free number which gives insured persons 24-hour access to a worldwide assistance network. For an emergency which occurs during the 60-day travel period, the network will provide the following emergency assistance services:

- physician and hospital referrals,
- ongoing monitoring of medical treatment if an insured person is hospitalized,
- coordination of transportation arrangements via ground or air ambulance if it is medically necessary to return an insured person to Canada or transfer them to another hospital that is equipped to provide the required treatment,
- payment assistance for hospital and medical expenses,
- legal referrals,
- a telephone interpretation service, and
- a message service for insured persons; messages will be held up to 15 days.

Emergency payment assistance
You must confirm your provincial health care coverage and coverage under the health provisions of this policy with our emergency assistance provider before receiving medically necessary services to ensure that any expenses you incur are paid. If you are not able to confirm with our emergency travel assistance provider before receiving services, you must do so as soon as is reasonably possible afterward. If you don't confirm coverage and services are received in circumstances where you could have reasonably contacted our emergency assistance provider, then we have the right to deny or limit payments for all expenses not confirmed. If we've paid for hospital and medical expenses on behalf of an insured person, you must sign an authorization form allowing us to recover the amount we've paid from the appropriate provincial health care plan.

If we've paid or have agreed to pay for expenses that require a portion to be paid by the insured person under this policy or the provincial health care plan, or are not covered under this policy, you must reimburse us for any amount payable by the insured person or not covered under these policies.

If we haven't paid for expenses incurred, we will only reimburse you when we receive proof satisfactory to us of your claim for reimbursement.

Hospital and medical services
We cover reasonable and customary charges for the following items, less the amount payable by a provincial health care plan:

- public ward accommodation and auxiliary hospital services in a general hospital,
- services of a physician,
- economy air fare to return the insured person to the province where they live for medical treatment,
- licensed ground ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada as determined by us or our emergency travel assistance provider,
- emergency air ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada as determined by us or our emergency travel assistance provider, when the insured person's physical condition prevents the use of another means of transportation, and
- the services and return air fare for a registered nurse when the insured person's physical condition prevents the use of another means of transportation, and the insured person requires a registered nurse during the flight.

The maximum lifetime amount we will pay for hospital and medical services is $1,000,000 for each insured person.

Expenses that are included as eligible expenses under other health benefits in this policy are also eligible while travelling outside Canada. These expenses are subject to the reimbursement percentages listed under the appropriate benefit in the *Plan summary*.

Travel assistance benefits
We cover reasonable and customary charges for the following family assistance benefits:

- return transportation for an insured person who is under age 16, or is handicapped, and they are left unattended because you or an insured person is hospitalized outside the province where you live. We will provide an escort to accompany them, if we or our emergency travel assistance provider determine it's necessary. The maximum payable for the return transportation is a one-way economy fare for each insured dependant who is under age 16, or who is handicapped,
- return transportation of any insured person, if their hospitalization or another insured person's hospitalization prevents them from returning home on the originally scheduled, pre-paid transportation, and they must purchase new return tickets. The extra cost of each return fare is payable to a maximum of a one-way economy fare, less any amount reimbursed for the unused return tickets,
- a visit of a spouse, parent, child, brother or sister, of the insured person when that insured person is hospitalized for more than seven days while travelling without a relative. The visit includes meals and accommodation up to a maximum of $150 per day, and round-trip economy transportation, for the person visiting. These expenses are also covered when it is necessary for one of them to identify a deceased insured person before the release of their body, and
- meals and accommodation up to a maximum of $150 per day (in total, not per person), if another insured person's trip is extended because an insured person is hospitalized.

The combined maximum amount we will pay for family assistance benefits is $5,000 for each travel emergency.

Repatriation
If an insured person dies while outside of the province where they lived, we will arrange for the necessary authorizations and the return of the deceased to the province where they last lived. Preparation of the deceased for repatriation includes expenses for cremation at the place of death. Return of the deceased includes a basic shipping container, but excludes expenses for burial, such as burial caskets and urns.

The maximum amount we will pay for the preparation and return of the deceased is $5,000.

Vehicle return
If an insured person is unable to operate a vehicle (owned or rented) because they are being returned to Canada for medical treatment, we will pay the cost of returning the vehicle to the province where they live, or the nearest appropriate rental agency. We will also pay this benefit when the insured person dies.

The maximum amount we will pay for returning the vehicle is $1,000.

Exclusions and limitations

At the time of an emergency, the insured person or someone present with the insured person must contact our emergency travel assistance provider. All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by our emergency travel assistance provider before being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to a hospital.

If you are not able to contact our emergency travel assistance provider before receiving services, you or someone present with the insured person must do so as soon as is reasonably possible afterward. If you don't contact our emergency travel assistance provider and emergency services are received in circumstances where you could have reasonably contacted our emergency assistance provided, then we have the right to deny or limit payments for all expenses related to that emergency.

An emergency ends when the insured person is medically stable to return to the province where they live.

We will not pay the expenses:

- for services that are not immediately required or which could reasonably be delayed until the insured person returns to the province where they live,
- for services relating to an illness or injury which caused the emergency, if they were received after the emergency ended,
- for services provided to the insured after the date that we or our emergency travel assistance provider, based on available medical evidence, determine that the insured person can be returned to the province where they live,
- for services received by the insured person for an illness or injury, including any complications if the insured person unreasonably refused or neglected to receive recommended medical services for that illness or injury,
- for services related to an illness or injury, including any complications or any emergency arising directly or indirectly from that illness or injury, where the trip was taken to obtain medical services for that illness or injury,
- incurred by an insured person for an emergency which occurs more than 60 days after departure from the province where they live,
- for the regular treatment of a chronic injury or illness. Emergency services do not include treatment provided as part of an established management program that existed before the insured person left their province of residence,
- due to or related to a pre-existing medical condition. A "pre-existing" medical condition is one where symptoms appeared or required medical attention, hospitalization or treatment (including changes in medication or dosage) during the nine-month period before the insured person's departure from the province where they live,
- due to pregnancy and incurred within four weeks of the insured person's expected date of delivery,
- for a child born outside of Canada until the later of their coverage effective date, or the date the child returns to Canada,
- incurred on a non-emergency or referral basis, and
- incurred under any of the conditions specified in the *General exclusions* section of the *General provisions* pages.

To determine eligibility, we may require the attending physician to provide medical evidence certifying that the insured person's medical condition was stable for a minimum period of nine months before the insured person traveled outside the province where they live. "Stable" means that the attending physician has stated that he does not expect a recurrence of the same medical condition or any problems related to that condition while the insured person travels outside the province where they live.

Due to conditions such as war, political unrest, epidemics, and geographic inaccessibility, emergency assistance services may not be available in certain countries.

Neither we nor the emergency travel assistance provider providing the assistance services is responsible for the availability, quality or results of the medical treatment received by the insured person, or for the failure to obtain medical treatment.

Semi-private hospital room coverage

Eligible expenses
We will cover eligible expenses based on the reimbursement percentage specified on the *Plan summary* page.

Eligible expenses mean the reasonable and customary charges for semi-private accommodation in a hospital limited to $200 per day up 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. If accommodation is in a convalescent hospital, we will pay $20 per day up to 180 days for hospital admission due to the same or related cause.

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 rentals, and
- expenses incurred under any of the conditions specified in the *General exclusions* section of the *General provisions* 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 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 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 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, except for orthodontic procedures where an expense is incurred for each appointment.

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 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).

Restorative dental procedures

- endodontics, such as root canal therapy, root canal fillings, and treatment of disease of the pulp tissue,
- periodontics – the treatment of disease of the gum and other supporting tissue,
- occlusal adjustment, also described as equilibration (not to exceed four time units per year),
- periodontal appliances (once every five years),
  - appliance maintenance (once every six months),
  - appliance reline,
  - post treatment evaluation,
- onlay restorations,
- crowns and repairs to crowns, other than prefabricated metal restorations,
- partial and complete dentures and repairs or additions to them,
- rebase or reline of a partial or complete denture,
- fixed bridgework and repairs to them,
- surgical services limited to:
  - alveoplasty,
  - dislocations,
  - enucleation of cysts,
  - frenectomy,
  - lacerations,
  - miscellaneous surgical services,
  - surgical extractions and repositioning (surgery requires surgical flap or sectioning of the tooth),
  - surgical excision,
- anaesthesia (if performed in conjunction with oral surgery),
  - conscious sedation,
  - deep sedation,
  - general anaesthesia, and
- drug injections.

Orthodontic procedures

- interceptive, interventive or preventive orthodontic services, other than space maintainers, and
- comprehensive orthodontic treatment, using a removable or fixed appliance, or combination of both. This includes diagnostic procedures, formal treatment and retention.

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.

The amount payable for an eligible restorative crown on a molar is limited to the fee charged for a metal restorative crown.

To determine the extent of damage to a crown or onlay, we will require the insured person or their dentist to submit x-rays and study models.

Replacement of an existing denture, bridgework, crown or onlay is an eligible expense if the replacement is required to replace an existing denture, bridgework, crown or onlay that was installed at least eight years before the replacement. We determine the maximum eligible expense based on the value and quality of the original denture, bridgework, crown or onlay.

The addition of teeth to an existing partial denture or bridgework is an eligible expense if the addition is required to replace one or more teeth removed while the insured person is insured under this policy.

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,
- services rendered in conjunction with surgical services payable under a government plan,
- crowns and onlays placed on a tooth not functionally impaired by incisal angle or cuspal damage,
- prosthetic devices which are ordered while an insured person is insured under this policy, but are installed after termination of this optional dental provision,
- initial dentures, bridgework or crowns to replace a tooth or teeth missing before becoming insured under this policy or to replace a tooth or teeth congenitally missing,
- replacement of dentures, crowns, onlays or bridgework and addition of teeth to existing dentures, crowns, onlays or bridgework except as provided above,
- replacement dentures which have been lost, stolen or misplaced,
- permanent splinting,
- full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
- replacement of orthodontic appliances which have been lost, stolen or misplaced,
- implants and transplants, and repositioning of the jaw,
- 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.

Appendix – Statutory conditions

The Policy

The application, the Policy particulars page, this policy and any amendment to the policy agreed upon in writing after this policy is issued, constitute the entire policy, and no agent has authority to change the policy or waive any of its provisions.

Waiver

We are deemed not to have waived any condition of this policy, either in whole or in part, unless our waiver is clearly expressed in writing signed by our authorized signing officers.

Copy of application

We will on your request, give you a copy of the application for this policy.

Material facts

No statement made by an insured person at the time of application for this policy can be used in defense of a claim under or to avoid this policy unless it is in the application or any other written statements or answers given as evidence of insurability.

Termination by us

We may terminate this policy at any time by giving written notice of termination to you and by refunding concurrently with the notice, the amount of premium paid in excess of the proportional premium for the expired time. The written notice may be delivered to you or sent by registered mail to the last address we have recorded for you in our records. Where notice is delivered to you, five calendar days notice of termination will be given. Where notice is sent by registered mail, ten calendar days notice will be given and the ten days begin on the day following the date of mailing.

Notice and proof of claim

You must send us written notice of all claims not later than the time period set out in your policy for making a claim by sending claims either by regular mail to us or electronically, where available.

You must give us any proof we consider is reasonably necessary for a claim.

Failure to give notice or proof

Failure to give notice of claim or provide proof of a claim within the time limit set out in this statutory condition does not invalidate the claim if you give notice or proof as soon as is reasonably possible and in no event later than12 months from the date that an eligible expense is incurred.

When money is payable

All money payable under this policy shall be paid by us within 60 days after we receive satisfactory proof of claim.

Insurer to furnish forms for proof of claim

We shall furnish forms for proof of claim within 15 days after receiving notice of claim, but where 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 giving rise to the claim.