UV INSURANCE

Insured: Ms. ABC
Contract No.: XXXXX
Certificate No. : XXX XXX XXX

Insurance Contract
Health insurance Contract

SAMPLE

10-day examination period

In the 10-day period following receipt of the present contract, you may return it to the company or to the agent from whom it was purchased. Full premium will be refunded and the contract will be void from the date of issue

Signed at the company's head office, in Drummondville, Quebec, Canada

_____
Eric Timmons, Secretary

_____
Christian Mercier, Chief Executive Officer

UV Insurance will pay the benefits in accordance with the provisions of this policy. UV Insurance is a business name and trademark of The Union Life Mutual Assurance Company.

UV INSURANCE

PARA MED+

Contract specifications

Name and address of the owner
Mr. ABC
3 Turgeon St.
Ste-Therese, Qc, J7E 3H2

Contract number : XXXXX
Certificate number : XXX XXX XXX

Renewal date : June 8th of each year

Insured (s)

	Name	Age at date of issue
Insured	Mr. ABC	42

Product **PARAMED +**

Date of issue 08-06-2022

SUMMARY OF BENEFITS AND PREMIUMS

Description	Issue date	Monthly premium
Extended health Plan 3 Optimum Single coverage Attained Age premium	08-06-2022	$ xx.xx
Prescription Drugs Insurance Plan 3 Optimum	08-06-2022	$ xx.xx
Dental Insurance Plan 2 Deluxe	08-06-2022	$ xx.xx
Travel Insurance	08-06-2022	$ xx.xx
Home Care Assistance Single coverage	08-06-2022	$ xx.xx

Total monthly premium : $ xxx.xx
Total annual premium : $ xxx.xx

SAMPLE

BENEFITS SCHEDULE Extended Health Insurance		Basic			
Benefit	**Description**	**Deductible**	**Coinsurance**	**Maximum per visit**	**Annual maximum per insured person**
The contract and rider terminate on the renewal following the primary insured's 99th birthday.					
PART I - Hospitalization					
Hospitalization, semi-private room		N/A	100 %	$200 per day	$3,000
Convalescent hospital		N/A	75 %	$40 per day	120 days
PART II – Prescription Drugs ***Note, this drug plan does not apply to an insured person residing in the province of Quebec**					
Drugs (Generics mandatory)		N/A	75 %		$850
Pay direct card					
PART III – Paramedical services *prescription required					
Acupuncturist		N/A	75 %	35 $	$300 per specialist Overall maximum of $1,000
Chiropractor		N/A	75 %	35 $	
Dietitian		N/A	75 %	35 $	
Homeopath		N/A	75 %	35 $	
Kinotherapist		N/A	75 %	35 $	
Massage therapist*		N/A	75 %	35 $	
Naturopath		N/A	75 %	35 $	
Osteopath		N/A	75 %	35 $	
Physiotherapist *		N/A	75 %	35 $	
Podiatrist or chiropodist		N/A	75 %	35 $	
Psychologist		N/A	75 %	35 $	
Speech-language pathologist		N/A	75 %	35 $	
Occupational therapist		N/A	75 %	35 $	
PART IV – Other expenses					
UPON A MEDICAL RECOMMANDATION					
Rental, purchase or repair of non-motorized wheelchair and hospital bed (excluding mattress)		N/A	75 %		Lifetime maximum of $5,000
Oxygen and rental equipment		N/A	75 %		
Diagnostic laboratory and X-ray procedures		N/A	75 %		$500
Private nurse		N/A	75 %		$10,000
Rental or purchase					
Orthopaedic corsets and hernia trusses		N/A	75 %		
Cervical collars		N/A	75 %		One per calendar year
Walkers or other mobility aids: canes, crutches, walking frames		N/A	75 %		
Orthopaedic devices		N/A	75 %		One per 60 months
Dextrometer or a glucometer for insulin-dependent diabetics		N/A	75 %		$200 per 36 months
Diabetic supplies		N/A	75 %		
Insulin pump & accessories		N/A	75 %		Lifetime maximum of $2,000
Magnetic resonance imaging (MRI)		N/A	75 %		$1,000

SAMPLE

BENEFITS SCHEDULE Extended Health Insurance		Basic			
Benefit	**Description**	**Deductible**	**Coinsurance**	**Maximum per visit**	**Annual maximum per insured person**
PART IV – Other expenses					
UPON A MEDICAL RECOMMANDATION					
Orthoses or arch support		N/A	75 %		$200
Supplies for colostomy, an ileostomy, or a urostomy		N/A	75 %		Unlimited
Rental or purchase of a TENS unit		N/A	75 %		$500
Purchase of an IUD		N/A	75 %		$100 per calendar year
Purchase of reagent strips, syringes and needles		N/A	75 %		Unlimited
Brassieres (following mastectomy)		N/A	75 %		2 per calendar year
Stockings for varicose veins and phlebitis		N/A	75 %		2 pairs per calendar year
Purchase of pressure garments for burns		N/A	75 %		$500 per 12 months
Maxi-mist machine, including the masks, or a CPAP machine		N/A	75 %		$1,500 per 60 months
WITHOUT A MEDICAL RECOMMANDATION					
Ambulance		N/A	75 %		Lifetime maximum of $5,000
Purchase of optical prosthesis or artificial limbs		N/A	75 %		Lifetime maximum one per eye or limb
External breast prosthesis following a mastectomy		N/A	75 %		$150 per 24 months
Purchase of a plaster casts		N/A	75 %		Unlimited
Hearing aids		N/A	75 %		$500 per 36 months
Wigs (required for pathological conditions or following chemotherapy treatments)		N/A	75 %		Lifetime maximum of $400
Cost of sclerotherapy		N/A	75 %	$25	15 visits per year
Dental care as the result of an accident		N/A	75 %		$5,000 per accident
Second medical opinion services					Included
Survivor benefits					24 months
PART V - Vision care services					
Eye examination by an optometrist or an ophthalmologist		N/A	75 %		$50 per 24 months
Contact lenses, glasses and frames		N/A	N/A		N/A
Intraocular lenses (eligible after 24 months of contract)		N/A	N/A		N/A
Overall maximum for PARTS I, II, III, IV and V					**$250,000**

SAMPLE

BENEFITS SCHEDULE Extended Health Insurance		Basic Ultra			
Benefit	**Description**	**Deductible**	**Coinsurance**	**Maximum per visit**	**Annual maximum per insured person**
The contract and rider terminate on the renewal following the primary insured's 99th birthday.					
PART I - Hospitalization					
Hospitalization, semi-private room		N/A	100 %	$200 per day	$3,000
Convalescent hospital		N/A	75 %	$40 per day	120 days
PART II – Prescription Drugs ***Note, this drug plan does not apply to an insured person residing in the province of Quebec**					
Drugs (Generics mandatory)		N/A	75 %		$1,000
Pay direct card					
PART III – Paramedical services *prescription required					
Acupuncturist		N/A	75 %	50 $	$300 per specialist Overall maximum of $1,000
Chiropractor		N/A	75 %	50 $	
Dietitian		N/A	75 %	50 $	
Homeopath		N/A	75 %	50 $	
Kinotherapist		N/A	75 %	50 $	
Massage therapist*		N/A	75 %	50 $	
Naturopath		N/A	75 %	50 $	
Osteopath		N/A	75 %	50 $	
Physiotherapist *		N/A	75 %	50 $	
Podiatrist or chiropodist		N/A	75 %	50 $	
Psychologist		N/A	75 %	50 $	
Speech-language pathologist		N/A	75 %	50 $	
Occupational therapist		N/A	75 %	50 $	
PART IV – Other expenses					
UPON A MEDICAL RECOMMANDATION					
Rental, purchase or repair of non-motorized wheelchair and hospital bed (excluding mattress)		N/A	75 %		Lifetime maximum of $5,000
Oxygen and rental equipment		N/A	75 %		
Diagnostic laboratory and X-ray procedures		N/A	75 %		$500
Private nurse		N/A	75 %		$10,000
Rental or purchase					
Orthopaedic corsets and hernia trusses		N/A	75 %		
Cervical collars		N/A	75 %		One per calendar year
Walkers or other mobility aids: canes, crutches, walking frames		N/A	75 %		
Orthopaedic devices		N/A	75 %		One per 60 months
Dextrometer or a glucometer for insulin-dependent diabetics		N/A	75 %		$200 per 36 months
Diabetic supplies		N/A	75 %		
Insulin pump & accessories		N/A	75 %		Lifetime maximum of $2,000
Magnetic resonance imaging (MRI)		N/A	75 %		$1,000

SAMPLE

BENEFITS SCHEDULE Extended Health Insurance		Basic Ultra			
Benefit	**Description**	**Deductible**	**Coinsurance**	**Maximum per visit**	**Annual maximum per insured person**
PART IV – Other expenses					
UPON A MEDICAL RECOMMANDATION					
Orthoses or arch support		N/A	75 %		$200
Supplies for colostomy, an ileostomy, or a urostomy		N/A	75 %		Unlimited
Rental or purchase of a TENS unit		N/A	75 %		$500
Purchase of an IUD		N/A	75 %		$100 per calendar year
Purchase of reagent strips, syringes and needles		N/A	75 %		Unlimited
Brassieres (following mastectomy)		N/A	75 %		2 per calendar year
Stockings for varicose veins and phlebitis		N/A	75 %		2 pairs per calendar year
Purchase of pressure garments for burns		N/A	75 %		$500 per 12 months
Maxi-mist machine, including the masks, or a CPAP machine		N/A	75 %		$1,500 per 60 months
WITHOUT A MEDICAL RECOMMANDATION					
Ambulance		N/A	75 %		Lifetime maximum of $5,000
Purchase of optical prosthesis or artificial limbs		N/A	75 %		Lifetime maximum one per eye or limb
External breast prosthesis following a mastectomy		N/A	75 %		$150 per 24 months
Purchase of a plaster casts		N/A	75 %		Unlimited
Hearing aids		N/A	75 %		$500 per 36 months
Wigs (required for pathological conditions or following chemotherapy treatments)		N/A	75 %		Lifetime maximum of $400
Cost of sclerotherapy		N/A	75 %	$25	15 visits per year
Dental care as the result of an accident		N/A	75 %		$5,000 per accident
Second medical opinion services					Included
Survivor benefits					24 months
PART V - Vision care services					
Eye examination by an optometrist or an ophthalmologist		N/A	75 %		$50 per 24 months
Contact lenses, glasses and frames		N/A	N/A		N/A
Intraocular lenses (eligible after 24 months of contract)		N/A	N/A		N/A
Overall maximum for PARTS I, II, III, IV and V					**$300,000**

SAMPLE

UV INSURANCE

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BENEFITS SCHEDULE Extended Health Insurance		Select			
Benefit	**Description**	**Deductible**	**Coinsurance**	**Maximum per visit**	**Annual maximum per insured person**
The contract and rider terminate on the renewal following the primary insured's 99th birthday.					
PART I - Hospitalization					
Hospitalization, semi-private room		N/A	100 %	$200 per day	$3,000
Convalescent hospital		N/A	75 %	$40 per day	120 days
PART II – Prescription Drugs ***Note, this drug plan does not apply to an insured person residing in the province of Quebec**					
Drugs (Generics mandatory)		N/A	75 %		$1,500
Pay direct card					
PART III – Paramedical services *prescription required					
Acupuncturist		N/A	75 %		$300 per specialist Overall maximum of $1,000
Chiropractor		N/A	75 %		
Dietitian		N/A	75 %		
Homeopath		N/A	75 %		
Kinotherapist		N/A	75 %		
Massage therapist*		N/A	75 %		
Naturopath		N/A	75 %		
Osteopath		N/A	75 %		
Physiotherapist *		N/A	75 %		
Podiatrist or chiropodist		N/A	75 %		
Psychologist		N/A	75 %		
Speech-language pathologist		N/A	75 %		
Occupational therapist		N/A	75 %		
PART IV – Other expenses					
UPON A MEDICAL RECOMMANDATION					
Rental, purchase or repair of non-motorized wheelchair and hospital bed (excluding mattress)		N/A	75 %		Lifetime maximum of $5,000
Oxygen and rental equipment		N/A	75 %		
Diagnostic laboratory and X-ray procedures		N/A	75 %		$500
Private nurse		N/A	75 %		$10,000
Rental or purchase					
Orthopaedic corsets and hernia trusses		N/A	75 %		
Cervical collars		N/A	75 %		One per calendar year
Walkers or other mobility aids: canes, crutches, walking frames		N/A	75 %		
Orthopaedic devices		N/A	75 %		One per 60 months
Dextrometer or a glucometer for insulin-dependent diabetics		N/A	75 %		$200 per 36 months
Diabetic supplies		N/A	75 %		
Insulin pump & accessories		N/A	75 %		Lifetime maximum of $2,000
Magnetic resonance imaging (MRI)		N/A	75 %		$1,000

SAMPLE

BENEFITS SCHEDULE Extended Health Insurance		Select			
Benefit	**Description**	**Deductible**	**Coinsurance**	**Maximum per visit**	**Annual maximum per insured person**
PART IV – Other expenses					
UPON A MEDICAL RECOMMANDATION					
Orthoses or arch support		N/A	75 %		$200
Supplies for colostomy, an ileostomy, or a urostomy		N/A	75 %		Unlimited
Rental or purchase of a TENS unit		N/A	75 %		$500
Purchase of an IUD		N/A	75 %		$100 per calendar year
Purchase of reagent strips, syringes and needles		N/A	75 %		Unlimited
Brassieres (following mastectomy)		N/A	75 %		2 per calendar year
Stockings for varicose veins and phlebitis		N/A	75 %		2 pairs per calendar year
Purchase of pressure garments for burns		N/A	75 %		$500 per 12 months
Maxi-mist machine, including the masks, or a CPAP machine		N/A	75 %		$1,500 per 60 months
WITHOUT A MEDICAL RECOMMANDATION					
Ambulance		N/A	75 %		Lifetime maximum of $5,000
Purchase of optical prosthesis or artificial limbs		N/A	75 %		Lifetime maximum one per eye or limb
External breast prosthesis following a mastectomy		N/A	75 %		$150 per 24 months
Purchase of a plaster casts		N/A	75 %		Unlimited
Hearing aids		N/A	75 %		$500 per 36 months
Wigs (required for pathological conditions or following chemotherapy treatments)		N/A	75 %		Lifetime maximum of $400
Cost of sclerotherapy		N/A	75 %	$25	15 visits per year
Dental care as the result of an accident		N/A	75 %		$5,000 per accident
Second medical opinion services					Included
Survivor benefits					24 months
PART V - Vision care services					
Eye examination by an optometrist or an ophthalmologist		N/A	75 %		$50 per 24 months
Contact lenses, glasses and frames		N/A	N/A		N/A
Intraocular lenses (eligible after 24 months of contract)		N/A	N/A		N/A
Overall maximum for PARTS I, II, III, IV and V					**$300,000**

SAMPLE

UV INSURANCE

PARA MED+

BENEFITS SCHEDULE Extended Health Insurance		Deluxe			
Benefit	**Description**	**Deductible**	**Coinsurance**	**Maximum per visit**	**Annual maximum per insured person**
The contract and rider terminate on the renewal following the primary insured's 99th birthday.					
PART I - Hospitalization					
Hospitalization, semi-private room		N/A	100 %	$200 per day	Unlimited
Convalescent hospital		N/A	80 %	$40 per day	120 days
PART II – Prescription Drugs ***Note, this drug plan does not apply to an insured person residing in the province of Quebec**					
Drugs (Generics mandatory)		N/A	80 %		$5,000
Pay direct card					
PART III – Paramedical services *prescription required					
Acupuncturist		N/A	80 %		$400 per specialist Overall maximum of $1,200
Chiropractor		N/A	80 %		
Dietitian		N/A	80 %		
Homeopath		N/A	80 %		
Kino therapist		N/A	80 %		
Massage therapist*		N/A	80 %		
Naturopath		N/A	80 %		
Osteopath		N/A	80 %		
Physiotherapist *		N/A	80 %		
Podiatrist or chiropodist		N/A	80 %		
Psychologist		N/A	80 %		
Speech-language pathologist		N/A	80 %		
Occupational therapist		N/A	80 %		
PART IV – Other expenses					
UPON A MEDICAL RECOMMANDATION					
Rental, purchase or repair of non-motorized wheelchair and hospital bed (excluding mattress)		N/A	80 %		Lifetime maximum of $5,000
Oxygen and rental equipment		N/A	80 %		
Diagnostic laboratory and X-ray procedures		N/A	80 %		$500
Private nurse		N/A	80 %		$10,000
Rental or purchase			80 %		
	Orthopaedic corsets and hernia trusses	N/A	80 %		
	Cervical collars	N/A	80 %		One per calendar year
	Walkers or other mobility aids: canes, crutches, walking frames	N/A	80 %		
	Orthopaedic devices	N/A	80 %		One per 60 months
	Dextrometer or a glucometer for insulin-dependent diabetics	N/A	80 %		$200 per 36 months
	Diabetic supplies	N/A	80 %		
	Insulin pump & accessories	N/A	80 %		Lifetime maximum of $2,000
	Magnetic resonance imaging (MRI)	N/A	80 %		$1,000

SAMPLE

BENEFITS SCHEDULE Extended Health Insurance		Deluxe			
Benefit	**Description**	**Deductible**	**Coinsurance**	**Maximum per visit**	**Annual maximum per insured person**
PART IV – Other expenses					
UPON A MEDICAL RECOMMANDATION					
Orthoses or arch support		N/A	80 %	$200	
Supplies for colostomy, an ileostomy, or a urostomy		N/A	80 %	Unlimited	
Rental or purchase of a TENS unit		N/A	80 %	$500	
Purchase of an IUD		N/A	80 %	$100 per calendar year	
Purchase of reagent strips, syringes and needles		N/A	80 %	Unlimited	
Brassieres (following mastectomy)		N/A	80 %	2 per calendar year	
Stockings for varicose veins and phlebitis		N/A	80 %	2 pairs per calendar year	
Purchase of pressure garments for burns		N/A	80 %	$500 per 12 months	
Maxi-mist machine, including the masks, or a CPAP machine		N/A	80 %	$1,500 per 60 months	
WITHOUT A MEDICAL RECOMMANDATION					
Ambulance		N/A	80 %	Lifetime maximum of $5,000	
Purchase of optical prosthesis or artificial limbs		N/A	80 %	Lifetime maximum one per eye or limb	
External breast prosthesis following a mastectomy		N/A	80 %	$150 per 24 months	
Purchase of a plaster casts		N/A	80 %	Unlimited	
Hearing aids		N/A	80 %	$500 per 36 months	
Wigs (required for pathological conditions or following chemotherapy treatments)		N/A	80 %	Lifetime maximum of $400	
Cost of sclerotherapy		N/A	80 %	$25	15 visits per year
Dental care as the result of an accident		N/A	80 %	$5,000 per accident	
Second medical opinion services				Included	
Survivor benefits				24 months	
PART V - Vision care services					
Eye examination by an optometrist or an ophthalmologist		N/A	80 %	$50 per 24 months	
Contact lenses, glasses and frames		N/A	100 %	$150 per 24 months	
Intraocular lenses (eligible after 24 months of contract)		N/A	100 %	Lifetime maximum of $500	
Overall maximum for PARTS I, II, III, IV and V				**$350,000**	

SAMPLE

BENEFITS SCHEDULE Extended Health Insurance		Optimum			
Benefit	**Description**	**Deductible**	**Coinsurance**	**Maximum per visit**	**Annual maximum per insured person**
The contract and rider terminate on the renewal following the primary insured's 99th birthday.					
PART I - Hospitalization					
Hospitalization, semi-private room		N/A	100 %	$200 per day	Unlimited
Convalescent hospital		N/A	90 %	$40 per day	120 days
PART II – Prescription Drugs ***Note, this drug plan does not apply to an insured person residing in the province of Quebec**					
Drugs (Generics mandatory)		N/A	90 %		$10,000
Pay direct card					
PART III – Paramedical services *prescription required					
Acupuncturist		N/A	90 %		$500 per specialist Overall maximum of $1,500
Chiropractor		N/A	90 %		
Dietitian		N/A	90 %		
Homeopath		N/A	90 %		
Kino therapist		N/A	90 %		
Massage therapist*		N/A	90 %		
Naturopath		N/A	90 %		
Osteopath		N/A	90 %		
Physiotherapist *		N/A	90 %		
Podiatrist or chiropodist		N/A	90 %		
Psychologist		N/A	90 %		
Speech-language pathologist		N/A	90 %		
Occupational therapist		N/A	90 %		
PART IV – Other expenses					
UPON A MEDICAL RECOMMANDATION					
Rental, purchase or repair of non-motorized wheelchair and hospital bed (excluding mattress)		N/A	90 %		Lifetime maximum of $5,000
Oxygen and rental equipment		N/A	90 %		
Diagnostic laboratory and X-ray procedures		N/A	90 %		$500
Private nurse		N/A	90 %		$10,000
Rental or purchase					
Orthopaedic corsets and hernia trusses		N/A	90 %		
Cervical collars		N/A	90 %		One per calendar year
Walkers or other mobility aids: canes, crutches, walking frames		N/A	90 %		
Orthopaedic devices		N/A	90 %		One per 60 months
Dextrometer or a glucometer for insulin-dependent diabetics		N/A	90 %		$200 per 36 months
Diabetic supplies		N/A	90 %		
Insulin pump & accessories		N/A	90 %		Lifetime maximum of $2,000
Magnetic resonance imaging (MRI)		N/A	90 %		$1,000

SAMPLE

BENEFITS SCHEDULE Extended Health Insurance		Optimum			
Benefit	**Description**	**Deductible**	**Coinsurance**	**Maximum per visit**	**Annual maximum per insured person**
PART IV – Other expenses					
UPON A MEDICAL RECOMMANDATION					
Orthoses or arch support		N/A	90 %	$200	
Supplies for colostomy, an ileostomy, or a urostomy		N/A	90 %	Unlimited	
Rental or purchase of a TENS unit		N/A	90 %	$500	
Purchase of an IUD		N/A	90 %	$100 per calendar year	
Purchase of reagent strips, syringes and needles		N/A	90 %	Unlimited	
Brassieres (following mastectomy)		N/A	90 %	2 per calendar year	
Stockings for varicose veins and phlebitis		N/A	90 %	2 pairs per calendar year	
Purchase of pressure garments for burns		N/A	90 %	$500 per 12 months	
Maxi-mist machine, including the masks, or a CPAP machine		N/A	90 %	$1,500 per 60 months	
WITHOUT A MEDICAL RECOMMANDATION					
Ambulance		N/A	90 %	Lifetime maximum of $5,000	
Purchase of optical prosthesis or artificial limbs		N/A	90 %	Lifetime maximum one per eye or limb	
External breast prosthesis following a mastectomy		N/A	90 %	$150 per 24 months	
Purchase of a plaster casts		N/A	90 %	Unlimited	
Hearing aids		N/A	90 %	$500 per 36 months	
Wigs (required for pathological conditions or following chemotherapy treatments)		N/A	90 %	Lifetime maximum of $400	
Cost of sclerotherapy		N/A	90 %	$25	15 visits per year
Dental care as the result of an accident		N/A	90 %	$5,000 per accident	
Second medical opinion services				Included	
Survivor benefits				24 months	
PART V - Vision care services					
Eye examination by an optometrist or an ophthalmologist		N/A	90 %	$75 per 24 months	
Contact lenses, glasses and frames		N/A	100 %	$200 per 24 months	
Intraocular lenses (eligible after 24 months of contract		N/A	100 %	Lifetime maximum of $500	
Overall maximum for PARTS I, II, III, IV and V				**$500,000**	

SAMPLE

BENEFITS SCHEDULE Dental Insurance	Basic	
Benefit	**Deductible**	**Coinsurance**
The contract and rider terminate on the renewal following the primary insured's 99th birthday.		
Basic care		
Diagnostic services (9 months recall) Preventive services (9 months recall) Minor restorations Oral surgeries Anesthesia Periodontic services Endodontic services	N/A	80% 80% 80% 80% 80% 80% 80%
Major restorations and major surgery		
Major restorations Oral surgery	N/A	0% 0%
Prosthetics		
Removable prosthesis Fixed prosthesis	N/A	0% 0%
Global maximum per insured person		
First year (12 consecutive months) Second year (Following 12 months) Following years	N/A	$500 $750 $1,000

SAMPLE

BENEFIT SCHEDULE Dental Insurance	Deluxe	
Benefit	**Deductible**	**Coinsurance**
The contract and rider terminate on the renewal following the primary insured's 99th birthday.		
Basic care		
Diagnostic services (9 months recall) Preventive services (9 months recall) Minor restorations Oral surgeries Anesthesia Periodontic services Endodontic services	N/A	80% 80% 80% 80% 80% 80% 80%
Major restorations and major surgery		
Major restorations Oral surgery	N/A	50% 50%
Prosthetics		
Removable prosthesis Fixed prosthesis	N/A	50% 50%
Global maximum per insured person		
First year (12 consecutive months) Second year (Following 12 months) Following years	N/A	$750 $1,100 $1,500

SAMPLE

BENEFIT SCHEDULE				
Travel Insurance				
Benefit	**Description**	**Deductible**	**Coinsurance**	**Maximums per insured per civil year**
Travel Insurance (termination at age 70)				
Travel Insurance	Trips of 90 days	N/A	100%	Lifetime maximum of $5,000,000
Trip Cancellation		N/A		$5,000 per trip
Medical Assistance		N/A		Included

SAMPLE

BENEFIT SCHEDULE		
Complimentary Drug Insurance - 1250		
***Please note that this drug plan is a complement to the one offered by the RAMQ and is only available to an insured person residing in the province of Quebec.**		
Benefit	**Coinsurance**	**Annual maximum per insured person**
Drugs (generics mandatory)	80%	$1,250
Pay direct card		

Annual Deductible	
Individual coverage: $50	Single Parent coverage : $100
Couple coverage : $100	Family coverage : $100

SAMPLE

BENEFIT SCHEDULE		
Complimentary Drug Insurance - 2500		
***Please note that this drug plan is a complement to the one offered by the RAMQ and is only available to an insured person residing in the province of Quebec.**		
Benefit	**Coinsurance**	**Annual maximum per insured person**
Drugs (generics mandatory)	80 %	$2,500
Pay direct card		

Annual Deductible	
Individual coverage: $50	Single Parent coverage : $100
Couple coverage : $100	Family coverage : $100

SAMPLE

BENEFIT SCHEDULE			
Home Care Assistance			
The follow expenses are eligible when the insured is physically dependant			
Eligible expenses	**Deductible**	**Coinsurance**	**Eligible maximum per insured**
The contract and rider terminate on the renewal following the primary insured's 99th birthday			
Monitoring system	N/A	100%	$1,000 per calendar year
Moving allowance	N/A	100%	$1,000 lifetime maximum
Meals	N/A	100%	$700 per month
Respite	N/A	100%	$3,000 per calendar year
Transportation expenses	N/A	100%	$750 per calendar year
Informal caregiver support	N/A	100%	$1,500 per calendar year
Private nurse or personal support worker	N/A	100%	$75 per day, maximum of $5,000 per calendar year

Maximum eligible amount for Home Care Assistance benefit	**$25,000**

SAMPLE

UV INSURANCE

PARA MED+

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GENERAL PROVISIONS

(The use of masculine nouns and pronouns in this contract is assumed to include the feminine equivalents.)

GENERAL INFORMATION

On the effective date of the contract, the Insurer accepts to cover the Insured against certain risks under the guaranteed coverage as specified in the “Benefit schedule”. Specific provisions apply to each coverage to explain their particularities.

In exchange of the Premium payment, when a risk for which an Insured is covered occurs, the Insurer agrees to pay the insurance amount shown in the “Benefit schedule” or any other amount as per the specific provisions applicable to a coverage, provided that the insured transmits all the information and documents deemed necessary for the request analysis.

INSURANCE CONTRACT

The contract is comprised of the policy and any rider, amendment and copy of any application attached to the policy. If the contract lapses and is subsequently reinstated, the written notice of reinstatement becomes an integral part of the contract.

DEFINITIONS

In the present contract, unless one of the benefits, a modification, a rider or the “Benefit schedule” stipulates otherwise, we hereby define:

a) ACCIDENT
A corporal blow diagnosed by a physician, arising directly and independently of all other causes, from the sudden, violent and unforeseeable action of an external cause.

b) AGE
Means the age of the insured person on his last birthday when stated or calculated, or on the day when an event referred to under the contract occurs, such as the effective date of the contract or the rider.

c) INSURANCE YEAR
The insurance year is twelve (12) months and begins on the contract effective date.

d) INSURED
The insured person except for the spouse and dependant children, as describe in this contract.

e) INSURER
UV Insurance. UV Insurance is a business name and trademark of The Union Life Mutual Assurance Company.

f) INJURY
Body lesions arising directly from an accident and independently of all other causes.

g) CO-INSURANCE
The percentage of eligible expenses reimbursed by the insurer to the insured person, after the deductible if applicable, as indicated in the "Benefit schedule".

h) SPOUSE
A person with whom the insured is living. The union must be a marriage duly recognised by Quebec legislation or the common-law state or a single, widowed or divorced person having resided permanently for more than one year with a person who is also single, widowed or divorced, who is publicly presented as a spouse. The stated delay is not applicable if a child is born of the union. The dissolution of a marriage by divorce as well as legal separation results in the loss of the marital status.

SAMPLE

The same loss of marital status results in the event of any de facto separation of more than three (3) months, in the case of a non-legally contracted union.

The spouse is the one designated by the insured. Only one person may be insured as a spouse at any given time.

i) DEPENDANT CHILD

Any unmarried child of the Insured (whether a natural child, a stepchild or an adopted child), of his or her spouse, or of both of them, who depends on the Insured for his or her support and who meets the following conditions:

1) must be at least twenty-four (24) hours of age and under twenty-one (21) years of age and doesn't work more than 20 hours per week, unless he is a full-time student;
2) is twenty-one (21) years of age or older but under twenty-six (26) years of age if he or she is a regular full-time day student in a recognized academic institution; or
3) regardless of age, has a physical or mental disability resulting from an accident or sickness that requires regular medical care. The disability must have begun while the child was considered a dependent as defined previously and be of such nature that the dependent is totally incapable of pursuing a gainful occupation.

j) IMMEDIATE FAMILY

The insured, his spouse, his children, his father, his mother, his grand-parents, his brothers, his sisters and his grand-children over the age of 18.

k) ELIGIBLE EXPENSES

Those costs incurred by the insured person for medical supplies or services that are considered to be refundable because they are:

- Medically necessary;
- Normal and reasonable;
- Prescribed by a physician or a health professional;
- Given by an approved provider.

Health services and treatments or products aren't eligible expenses if they were given or prescribed by the insured himself, or by a member of his immediate family, a colleague or his employer.

l) NORMAL AND REASONABLE EXPENSES

Fees or charges that do not exceed the amounts generally charged by other professionals, similar health care establishments, or pharmacies in the same jurisdiction for identical or comparable care, services, or supplies.

m) FEE SCHEDULE

Refers to the fee schedule suggested for dental services and indicated in the fee guide in the province of residence of the insured.

n) DEDUCTIBLE

The deductible is the portion of eligible expenses that must be paid by the insured in each calendar year before a benefit is payable. If applicable, the deductible amount is specified in the "Benefit schedule".

o) ILLNESS

A deterioration of health or disorder of the organism diagnosed by a physician specialised in the treatment of the illness. Pregnancy is not considered to be an illness; only major complications due to pregnancy are considered to be a deterioration of health.

p) PHYSICIAN

Any legally authorised person who practices medicine in his field of specialty. The physician must not be the insured, or a member of his immediate family.

q) INSURED PERSON

The insured, spouse and a dependant child as specified in this contract.

r) HEAD OFFICE

P.O. Box 696, Drummondville, Quebec, J2B 6W9.

SAMPLE

ELIGIBILITY

To be eligible for coverage under this present contract, the insured must reside in Canada and be insured under their province of residence government hospitalization plans and provincial health care programs.

EFFECTIVE DATE OF CONTRACT

This contract shall take effect as soon as the application is approved by the Insurer at its head office and those conditions are met:

- the first premium has been paid
- there has been no change in the insurability of the person to be insured between the date the application was signed and the date the contract is delivered.

LAPSE

The contract lapses and our obligations hereunder cease automatically if premiums remain unpaid after the grace period.

INCONTESTABILITY

Once this contract has been in force for two (2) years while the insured is alive, subject to any legislation governing this contract, the statements made in the application are accepted as true and incontestable, in the absence of fraudulent statements or erroneous statements relating to age. If the contract lapses and is subsequently reinstated, this clause is valid as of the date of reinstatement. Upon the addition of a plan, rider or benefit to this contract, this provision applies as of the date such plan, rider or benefit comes in force.

MODIFICATIONS

This contract may be modified at any time following a written request by the insured and with the agreement of the Insurer with a rider duly signed by an authorized employee of the Insurer.

Any change request is subject to the Insurer's administrative rules in force at the moment of the request.

PAYMENT OF PREMIUMS

Premiums are payable in advance at the Insurer's head office starting on the effective date of the contract. You may, at any time, request that the method of premium be changed, subject to our administrative rules.

Any premium paid is acquired by the Insurer.

GRACE PERIOD

A premium, other than the first, can be paid within a period of thirty (30) days from its due date. During this period, the contract remains in force but no benefits are payable until the payment date.

NOTICE AND PROOF OF CLAIM

In case of a claim for an amount payable in accordance to this contract, the Insurer may demand such evidence as is necessary to establish the validity of the claim.

a) FILING A CLAIM

Any claim for benefits under this contract must be filed with the Insurer through a written notice within ninety (90) days following the end of the calendar year of the event.

b) PROOF OF CLAIM

The insured must submit to the Insurer the required proof according to the benefit in the ninety (90) days following the end of the calendar year of the event. It is the insured's responsibility to assume all expenses incurred to obtain the satisfactory evidences.

In case of a claim for an amount payable in accordance to this contract, the Insurer may demand such evidence (medical or personal) as is necessary to establish the validity of the claim.

SAMPLE

PAYMENT

The Insurer must pay claims within a maximum of thirty (30) days following the date of receipt of all required proof. No amount will be paid if the insured or any person acting on its behalf refuses to submit the required documents to review the claim.

All amounts become payable to the insured, if living. Otherwise, the amounts are payable to the insured's estate.

CANCELLATION

1. **CANCELLATION BY THE INSURED**

The insured can terminate this contract by sending a written and signed request to the Insurer or its representative. The termination date is the date the request is received. If the premium is paid monthly, the request must be received within ten (10) business days of the withdrawal date, otherwise the premium will be debited and the termination date will be according to the period covered by this last premium.

2. **CANCELLATION FOR NON-PAYMENT OF PREMIUM**

Subject to any provisions to the contrary stated in the contract, when a premium is past due at the end of the grace period, this contract is cancelled and lapse.

3. **CANCELLATION FOR FALSE STATEMENT**

Subject to the incontestability section, in case of the omission to disclose important information or to accurately state important facts to the Insurer that would have resulted in a different underwriting decision, this contract is cancelled and becomes void.

No benefits should have been paid and the Insurer will pay a final settlement equal to the total Premiums paid, without interest, minus all benefits paid. An amount could be owed and charged to the insured.

4. **CANCELLATION FOR FRAUDULENT STATEMENT**

When a false statement is done by the insured with the intent to mislead and/or adversely affect the Insurer, this contract is cancelled and becomes void.

Without limiting the foregoing, a fraudulent statement means:

- Failing to inform the Insurer of a material fact;
- Inaccurately representing a material fact in the application, during a medical examination, or in any other information that we have used as proof of insurability.

No benefits should have been paid and the Insurer will pay a final settlement equal to the total Premiums paid, without interest, minus all benefits paid. An amount could be owed and charged to the insured.

TERMINATION BY THE INSURER

As long as the insured pays the premiums, the insurer cannot terminate a contract before the insured person reaches the maximum age.

REINSTATEMENT

This contract may be reinstated while the insured is alive during a period of two (2) years from the date of cancellation by providing satisfactory proof of insurability to the Insurer and by paying the outstanding premiums.

PARTICIPATION IN PROFITS

This contract does not participate in the Insurer's profits.

ASSIGNMENT OR PLEDGE

Insurance under this contract may not be assigned or pledged.

SAMPLE

CONTRACT'S RENEWAL

Provided that no premium is outstanding on the last day of an insurance year, this contract is automatically renewed each year.

As long as the insured pays the premiums, the insurer cannot terminate a contract before the insured person reaches the maximum age specified for each benefit.

PREMIUM RATE DETERMINATION

FOR PREMIUM AT ATTAINED AGE

The insurer determines the premium rate according to the chosen coverages, the gender and the age of the insured on the proposition's signature date. At renewal, the premium rate is determined according to the chosen coverages, the gender and the insured's attained age on the contract's anniversary date.

FOR LEVELED PREMIUM RATES

The insurer determines the premium rate according to the chosen coverages, the gender and the age of the insured on the proposition's signature date. At renewal, the premium rate is determined according to the chosen coverages, the gender and the insured's age on the proposition's signature date.

MODIFICATION OF PREMIUM RATES

On a yearly basis, on the contract's anniversary, the Insurer reserves the right to modify the unit rates as long as the unit rates for identical contracts are modified. A written notice must be sent to the insured at least thirty (30) days before any change is made to the premium rates. No increase in premium can be applied less than twelve (12) months following a previous increase, unless a modification has been requested by the insured.

However, the Insurer reserves the right to modify the rates at any time following changes in provincial or federal legislation that impacts:

- Insurance premium taxation;
- Eligible expenses covered in this contract.

SUBROGATON

When any amount is paid out to a person under the health or dental insurance coverage provided by this contract subsequent to an accident or illness for which a third party is legally liable, the Insurer is subrogated in the rights of the Insured person and may recover from the liable third party the amounts paid out to the extent permissible by law.

COLLECTION

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

LEGAL CURRENCY

All amounts payable to or by the Insurer under this contract are payable in Canadian currency.

ERROR IN DECLARATION OF AGE

If the age of the Insured person under the contract has been misstated, the premium payable will be adjusted by the Insurer to the amount that would have been payable had the Insured's age been correctly stated at contract issue.

If on the date of issue of the contract the age of the Insured person was outside the applicable age limits, the contract will be deemed void, subject to any legal restrictions.

An error concerning the insured's age cannot extend any amount of insurance beyond the date these amounts would have terminated, taking into account the insured's actual age.

TERMINATION OF INSURANCE

The insurance of an insured person, under this contract, will terminate on the earliest of the following dates at midnight:

a) the cancellation date of your Contract or benefit;

SAMPLE

b) date the insured no longer meets the eligibility requirements;

c) date the spouse or dependant children no longer meet the definition;

d) the insurance for a dependant ends on the date the insured is no longer eligible;

e) date the Insurer receives the termination written notice from the insured or at any other later date indicated on that notice;

f) termination date indicated in the “Benefit schedule”.

LAWS THAT GOVERN THIS CONTRACT

The Contract shall be governed by the laws of the province or territory in which the application was signed and by any applicable federal laws.

FILE ACCESS

In order to maintain the confidential nature of personal information on the insured, the Insurer agrees to the following:

To create an individual insurance file that contains information on the insured relating to the application, as well as any information relating to the claim.

Access to the file is restricted solely to the Insurer’s employees, legal advisors or representatives responsible for the underwriting, investigations and evidence of insurability.

The insured’s file is kept by The Union Life Mutual Assurance Company and its representative. The insured has the right to be informed of the personal information in this file and if applicable, may have it corrected by making a written request to the Insurer. All requests are to be sent to the access information officer.

SAMPLE

EXTENDED HEALTH INSURANCE BENEFIT WITH PRESCRIPTION DRUGS

This benefit includes hospitalization, Health and Paramedical Expenses Insurance (including drugs).

PURPOSE OF THE COMPLEMENTARY HEALTH INSURANCE BENEFIT

Provided that this coverage is in force when the insured person incurs expenses following an illness or accident, the Insurer shall reimburse, in accordance with the settlement terms indicated in the "Benefit schedule" and all other provisions of the contract, the eligible expenses described below.

ELIGIBILITY AND CONDITIONS

An insured person is eligible for this coverage only if he or she is also eligible for the benefits available under their province of residence government hospitalization plans and provincial health care programs.

This coverage provides for the reimbursement of reasonable, usual, and customary expenses contracted for services, supplies, and medical care in Canada described in the "Benefit schedule", except for the applicable exclusions.
Expenses must be incurred in the province of residence of the insured.

DEFINITIONS:

a) HOSPITAL

Means a short or long-term clinic as established by the laws in force, excluding extended health care centre.
Centres that are reserved for youths, a clinic for people with a mental deficiency or with tuberculosis, a sanatorium, a nursing home, a rehab centre, centres offering respite care for physically or mentally challenged persons or centre offering keeping care are not considered a hospital.

b) CONVALESCENCE HOSPITAL

Means a centre offering convalescence services to patients that are always under the direct services of a physician. The centre must be registered under the appropriate governmental organism and must offer permanent nursing services.

Centres that are reserved for youths, clinic for people with a mental deficiency or with tuberculosis, a sanatorium, a nursing home, a rehab centre, centres offering respite care for physically or mentally challenged persons or centre offering keeping care are not considered a convalescence hospital.

c) INTERCHANGEABLE DRUG

Means an innovative drug and its approved generic equivalent.

ELIGIBLE EXPENSES

For each insured persons, the Insurer reimburses, subject to the deductible, the co-insurance and up to the maximum amounts, the usual and customary expenses indicated in the "Benefit schedule":

SAMPLE

PART I

HOSPITALIZATION

The purpose of hospitalization insurance is to refund an amount for each day that an insured person, due to illness or injury, spends in a hospital or a convalescence hospital upon recommendation of a physician, subject to a deductible, a percentage of refund and up to the maximum amounts indicated in the "Benefit schedule".

a) SHORT-TERM HOSPITALIZATION
The cost to stay in a hospital room as stipulated in the "Benefit schedule" in a hospital for short-term care, less the fees that are refunded or refundable by a governmental insurance plan.
Eligible short-term care includes prevention, medical diagnosis and medical treatment for acute illnesses.

b) CONVALESCENCE HOSPITAL
The cost to stay in a hospital room as stipulated in the "Benefit schedule" in a convalescence hospital, less the fees that are refunded or refundable under a governmental insurance plan, while this plan is in effect.
The insured person must be admitted within fourteen (14) days after leaving the hospital for which he was receiving short-term care or had been admitted for less than one (1) day for an operation requiring local anaesthesia. Eligible expenses are limited to a maximum period as stipulated in the "Benefit schedule".

PART II

PRESCRIPTION DRUGS

FOR INSURED RESIDING IN CANADA (EXCEPT FOR THE PROVINCE OF QUEBEC)

The Insurer pays, after subtracting the deductible, based on the percentage indicated for this purpose and up to the maximum indicated in the "Benefit schedule", expenses for medication necessary for the treatment of an illness or accident that can only be obtained when prescribed by a physician, a dentist or any other health professional authorized to prescribe drugs under the provincial laws of the insured's province of residence

Eligible drugs must:

1. Be given by a pharmacist or any other provider approved by the Insurer;
2. Be approved by Health Canada;
3. Have an identifying number (DIN).

Only the cost of an interchangeable drug will be taken into account when the cost of the original medication is higher than that of the generic, unless the physician writes and justifies that no substitution is possible.

A maximum provision of 90 days is allowed (30 days may apply for some drugs).

QUEBEC – FOR THE INSURED RESIDING IN THE PROVINCE OF QUEBEC

The insurer reimburses the deductible and co-insurance that the insured person must assume and pay under the general plan provided for in the Quebec Act respecting prescription drug insurance and administered by the Régie de l'assurance- Maladie du Québec. subject to the deductible, co-insurance and up to the maximum indicated in the "Benefit schedule".

Also the Insurer pays, after subtracting the deductible, based on the percentage indicated for this purpose and up to the maximum indicated in the "Benefit schedule", expenses for medication necessary for the treatment of an illness or accident that can only be obtained when prescribed by a physician, a dentist or any other health professional authorized to prescribe drugs under the provincial laws of the insured's province of residence

SAMPLE

Eligible drugs must:

1. Be given by a pharmacist or any other provider approved by the Insurer;
2. Be approved by Health Canada;
3. Have an identifying number (DIN).

Only the cost of an interchangeable drug will be taken into account when the cost of the original medication is higher than that of the generic, unless the physician writes and justifies that no substitution is possible.

A maximum provision of 90 days is allowed (30 days may apply for some drugs).

PART III

PARAMEDICAL SERVICES

Expenses for Paramedical services, subject to the deductible, the percentage of refund and up to the maximum indicated in the Benefit schedule, provided by a/an:

- Acupuncturist
- Chiropractor
- Dietitian
- Homeopath
- Kinotherapist
- Massage therapist *
- Naturopath
- Osteopath
- Physiotherapist *
- Podiatrist or chiropodist
- Psychologist
- Occupational therapist
- Speech-language pathologist

*Only covered if prescribed by a physician

The maximum amount and number of visits per calendar year for each above-mentioned specialist or each grouping of specialists are indicated in the “Benefit schedule”.
Specialists must be members of their professional association, recognised by the insurer, and they must provide services that fall within their specialty. They must not be a member of the insured’s immediate family.
In addition, eligible expenses per insured person are limited to one (1) visit per day per specialist.

PART IV

OTHER EXPENSES

The following expenses, subject to the deductible, the percentage of refund and up to the maximum indicated in the Benefit schedule, are covered on the condition that they are prescribed by a physician and are necessary for treatment of an illness or an accident and are normal and reasonable with current medical procedures:

a) rental or purchase, whichever is deemed more economical by the Insurer of a non-motorized wheelchair, a standard hospital bed (excluding mattress) and any other equipment normally considered to be used in a hospital for the purpose of temporary treatment;

b) The cost of oxygen, as well as the rental or purchase, whichever is deemed more economical by the Insurer, of the equipment necessary to administer it. The insured must obtain prior authorization from the Insurer before any purchase or rental. Failure to obtain this authorisation may result in the Insurer’s rejection of the claim;

c) when deemed necessary for prevention or diagnosis, the following laboratory analysis, x-ray procedures such as computer tomography (scanners), ultrasounds, electrocardiograms, mammograms, x-rays (except for teeth and orthosis) expenses subjected to a maximum indicated in the “Benefit schedule” per period of 12 consecutive months;

d) The service of a registered private nurse outside of the hospital required after a hospitalization or surgical intervention requiring local anaesthesia performed at the hospital. The insured must obtain authorization from the Insurer for these services. The nurse must be a member of a professional association in the insured’s province of residence;

e) rental or purchase, whichever is deemed more economical by the Insurer, of the following medical supplies or equipment:

SAMPLE

a. orthopaedic corsets and hernial trusses;

b. cervical collars;

c. walkers or other mobility aids required for temporary therapeutic use, such as crutches, canes or walking frames;

d. orthopaedic devices that help to keep a part of the body properly positioned. Elastic support bandages and foot orthoses are not covered in this category);

f) the purchase or repair of a glycemic-control mechanism such as a glucose monitor, an insulin dosing system, a pressure insulin injector or any other approved system by the Insurer is payable upon presentation of a complete report from a physician certifying that the insured is insulin-dependant;

The insulin pomp isn't eligible under this description but under the description « Insulin Pump »

g) expenses for the following diabetic supplies:

a. blood letting device, including platforms but excluding lancets;

b. Insulin infusion sets, excluding infusion pump;

The glucoses sensors are not eligible;

h) expenses of an insulin pump and its accessories for type1 diabetes;

i) when deemed necessary for prevention or diagnosis, nuclear magnetic resonance imaging, subject to a maximum indicated in the "Benefit schedule" per period of 12 consecutive months;

j) the cost of corrective devices or the purchase of custom-made orthoses or arch supports and the cost of custom fitted orthopaedic shoes manufactured especially for the Insured person in a dedicated orthopaedic laboratory , up to the maximum amount and period indicated in the "Benefit schedule". The orthoses may also be prescribed by a podiatrist;

k) the cost of eligible supplies that become necessary following a colostomy, an ileostomy or a urostomy;

l) rental or purchase, whichever is deemed more economical by the Insurer, of a transcutaneous electric neurostimulator unit (tens). The insured must obtain authorization from the Insurer before making any purchase or rental. Failure to obtain this authorisation may result in the Insurer's rejection of the claim;

m) the purchase of an IUD;

n) the purchase of reagent strips, syringes and needles for diabetics;

o) the purchase of brassieres (following mastectomy);

p) the purchase of elastic stockings for varicose veins or phlebitis sold by a specialized firm;

q) pressure garment for major burns;

r) rental or purchase, whichever is deemed more economical by the Insurer, of a Continuous Positive Airway Pressure apparatus (CPAP) or of a maxi-mist machine, including the masks.

All the following expenses are covered without being prescribed by a physician:

s) in emergency situations that happened in the insured's province of residence, the expenses for transportation to a hospital in a duly authorised ambulance, as well as air or train transport to the nearest hospital, if the insured person cannot be transported in any other means;

t) the purchase of optical prostheses or artificial limbs. A single optical prosthesis per eye and a single artificial limb per amputated limb is covered for the lifetime of the insured person.

u) the purchase of external breast prostheses necessary following a mastectomy, in excess of the amount covered by a governmental plan, subject to an external breast prostheses per period of 24 months;

v) the purchase of plaster cast;

w) the purchase or repair of a hearing aid prescribed by an audiologist, up to the maximum amount indicated in the "Benefit schedule" per period of 36 consecutive months;

x) the purchase of a wig required for pathological conditions or following chemotherapy treatments;

y) the cost of sclerotherapy administered by a physician (solution only);

z) subject to prior evaluation by the Insurer, expenses for professional services rendered by a dental surgeon to repair damage cause to natural, healthy and whole teeth in an accident that occurred while the insured person was covered under this benefit and providing that treatment is given within

SAMPLE

six (6) months of the accident providing this plan is still in effect when the care is provided and the expenses are incurred in the insured's province of residence.

Eligible expenses are determined using the amounts indicated in the suggested fee guides for dental services, in force in the province where the services are given and when expenses are incurred.

Accidental damages to the teeth that occurs while eating are excluded.

PART V

VISION CARE SERVICES

Subject to the deductible, the percentage of refund and up to the maximum indicated in the « Benefit schedule », the following expenses are covered:

1. the cost of corrective lenses and eyeglass frames or the cost of contact lenses, when prescribed by an ophthalmologist or an optometrist, up to the amount and period indicated in the "Benefit schedule". Expenses for the purchase of sunglasses or security glasses, with or without corrective lenses aren't eligible;
2. the cost of an eye examination by an ophthalmologist or an optometrist authorized, up to the amount and period indicated in the "Benefit schedule";
3. contact lenses or intraocular lenses following a cataract surgery, up to the lifetime maximum indicated in the "Benefit schedule".

OVERALL MAXIMUM

The overall maximum applicable per insured person is for Parts I, II, III, IV and V combined as indicated in the Benefit Schedule.

COORDINATION OF BENEFITS

Benefits payable under this coverage are reduced in such a way that, when these benefits are added to any other benefits provided through any other insurance plan, private or public, covering the same insurable expenses, the overall benefits do not exceed the actual amount of expenses incurred.
This present plan covers the expenses exceeding all other coverages under which the insured is eligible. If the other plan or plans of the insured have a maximum eligible high enough to cover the entire claim, no benefit will be payable. This plan is the second payer.

PROOF OF CLAIM

Eligible expenses are refundable upon presentation of original receipts.
To establish proof of claim, the insured must submit to the Insurer original receipts from the suppliers providing treatments or products.
The insured must submit to a medical examination when the Insurer is justified in requesting it considering the type of treatments that are required by the insured person's state of health. In the event of a medical examination, the physician is designated and paid by the Insurer.
The Insurer may also request, at the insured's expense, a report from the health professional that is treating the insured person. The Insurer may request declarations from the person claiming benefits, as well as the use of the Insurer's forms.

SURVIVOR BENEFITS

If, at the time of the Insured's death, his or her dependents are covered by this coverage, this insurance coverage remains in force without further payment of premiums. However, this coverage ends on the first of the following date:

a) twenty-four (24) months after the Insured's death;

b) the date the spouse or a dependent no longer meets the requirements mentioned in the definition of a dependent;

SAMPLE

c) The date that a similar coverage with another insurer goes into effect;

d) The date this benefit or contract terminates.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the insured's insurance stipulated in the section entitled "General provisions" of the present contract, the insured's insurance for this benefit will terminate on the earliest of the following dates at midnight:

a) date the Insurer receives the termination written notice from the insured or at any other later date indicated on that notice;

b) date the insured no longer meets the eligibility requirements or definition;

c) termination date indicated in the "Benefit schedule".

EXCLUSIONS

NO BENEFIT IS PAYABLE FOR LOSSES RESULTING FROM THE FOLLOWING CAUSES OR INCIDENTS:

a) the insured person's participation in a criminal act or attempted criminal act;

b) injury or illness resulting from the insured person's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not;

c) suicide or any self-inflicted wound or mutilation, regardless of the insured person's state of mind;

d) incurred expenses for treatment not medically required, or for cosmetic purposes or treatments that exceeds usual care normally applied for therapeutic purposes;

e) all expenses that are payable or refundable under any governmental insurance plan or normally would be, or private plan;

f) all expenses arising from an illness or accident falling under the authority of a provincial organism of the insured's province of residence, like the CNESST or the Société de l'assurance automobile du Québec (SAAQ);

g) all expenses in excess of those considered reasonable, taking into consideration the importance of the situation, the normal rates in the region and the procedure that is normally used;

h) all treatments or services that are provided free of charge or that would be free in the absence of insurance or that are not at the insured's expense;

i) expenses incurred for a health trip, a rest cure, diet purposes or weight-loss treatments;

j) treatments or services given by a member of the insured person's immediate family;

k) medical expenses resulting from any illness or injury attributable to an occupation or employment for wages or profit;

l) expenses for varicose vein injections in the lower limbs, giving in a nonmedical purpose;

m) any drug that is available to the general public without a medical prescription;

The following are not considered as drugs for the purpose of this benefit and are therefore not refundable:

aa) any drug that is available to the general public without a medical prescription;

bb) milk, regardless of its nature, or milk substitutes;

cc) proteins, dietary supplements, food, homeopathic or so-called natural products;

dd) products for aesthetic or cosmetic care;

ee) products, hormones and injections for cellulites or obesity treatment, including anorexiants;

ff) products or medication used for eliminating the use of tobacco;

SAMPLE

gg) mineral water;

hh) disinfectants, lubricating eye drops and solutions for contact lenses;

ii) soaps, oils, shampoos and other hair products, emollients, creams and cough drops;

jj) vitamins;

kk) drugs administered for preventive measures. Under this exclusion, a drug used to stabilise or regulate a pathological state diagnosed by a physician is not considered as a preventive drug;

ll) drugs or substances used in the treatment of infertility or impotence;

mm) all substances used for insemination or contraceptive gels or foams;

nn) anabolic steroids, growth hormones or experimentally administered drugs;

oo) drugs provided during hospitalization.

EXPERT MEDICAL OPINION

Any Insured covered under this insurance benefit is entitled access to a second medical opinion benefit. The current provider of this benefit is Best Doctors; however, the provider and the services offered are subject to change at UV Insurance's discretion

Best Doctors

Coverage begins on the effective date of this policy, provided that the Insured meets the eligibility criteria and that Best Doctors services are available.

Best Doctors helps you make medical decisions with confidence. They provide access to the best medical minds in the world so you can feel empowered with the right information about your diagnosis and treatment plan. They also help you find specialists and get expert answers to medical questions. Whether you're dealing with a chronic condition, questioning surgery or facing a life-threatening illness, Best Doctors can guide you in the right direction.

You have unlimited access to the following Best Doctors services:

Expert Medical Opinion*

When a second opinion is required regarding a medical diagnosis or treatment plan, Best Doctors experts will conduct an in-depth analysis of your medical records, including imaging scans, X-rays, test results and any available pathology (which can be retested). You will receive a written report of their findings, which includes a diagnosis and treatment recommendations that you can share with your doctor.

FindBestDoc*†

If you're searching for a local specialist let Best Doctors do the work for you. They will search their database of top Canadian specialists and take into account your unique medical history and geographic location, matching you with the right physician for your condition.

FindBestCare*†

If you need a specialist outside of Canada* they can make it possible through their FindBestCare service. They will cater the search to your unique medical history and geographic location, as well as availability of the specialist and/or facility.

Best Doctors 360°®*
Best Doctors 360° can help you navigate the Canadian healthcare system and get you the information you need for a variety of health topics. Best Doctors provides you with a variety of tools and resources when you're facing medical uncertainty, and can offer advice and wellness support if you need it. You'll gain peace of mind knowing you're making an informed decision about your health care.

SAMPLE

* Individuals are responsible for any expenses associated with medical treatment, travel and lodging.
† Best Doctors does not make referrals or appointments for members.

Get started today

Go online at bestdoctors.com/canada/start or call 1-877-419-2378. You need to identify yourself by providing your insurance policy number. When you contact Best Doctors, you will be assigned a Member Advocate who will assess your medical issue, answer your questions, determine what service would best meet your needs and keep you informed about the progress of your case.

About Best Doctors

Founded in 1989 by Harvard Medical School physicians, Best Doctors is a benefit that provides access to the best medical minds in the world so you can feel empowered with the right information. It is designed to complement the care you receive from your own physician.

Best Doctors uses the top 5% of medical experts in the world to provide you with the right advice at the right time so you can make informed medical decisions with confidence.

Best Doctors is now part of Teladoc Health, the global leader in virtual care.

Best Doctors and the star-in-cross logo are trademarks of Teladoc Health, Inc., in the United States and in other countries, and are used under license.

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EXTENDED HEALTH INSURANCE BENEFIT WITHOUT PRESCRIPTION DRUGS

This benefit includes hospitalization, Health and Paramedical Expenses Insurance (excluding prescription drug for all provinces in Canada).

PURPOSE OF THE COMPLEMENTARY HEALTH INSURANCE BENEFIT

Provided that this coverage is in force when the insured person incurs expenses following an illness or accident, the Insurer shall reimburse, in accordance with the settlement terms indicated in the Benefit Schedule and all other provisions of the contract, the eligible expenses described below.

ELIGIBILITY AND CONDITIONS

An insured person is eligible for this coverage only if he or she is also eligible for the benefits available under their province of residence government hospitalization plans and provincial health care programs.

This coverage provides for the reimbursement of reasonable, usual, and customary expenses contracted for services, supplies, and medical care in Canada described in the Benefit Schedule, except for the applicable exclusions.

Expenses must be incurred in the province of residence of the insured.

DEFINITIONS:

d) HOSPITAL

Means a short or long-term clinic as established by the laws in force, excluding extended health care centre.

Centres that are reserved for youths, a clinic for people with a mental deficiency or with tuberculosis, a sanatorium, a nursing home, a rehab centre, centres offering respite care for physically or mentally challenged persons or centre offering keeping care are not considered a hospital.

e) CONVALESCENCE HOSPITAL

Means a centre offering convalescence services to patients that are always under the direct services of a physician. The centre must be registered under the appropriate governmental organism and must offer permanent nursing services.

Centres that are reserved for youths, clinic for people with a mental deficiency or with tuberculosis, a sanatorium, a nursing home, a rehab centre, centres offering respite care for physically or mentally challenged persons or centre offering keeping care are not considered a convalescence hospital.

f) INTERCHANGEABLE DRUG

Means an innovative drug and its approved generic equivalent.

ELIGIBLE EXPENSES

For each insured persons, the Insurer reimburses, subject to the deductible, the co-insurance and up to the maximum amounts, the usual and customary expenses indicated in the Benefit Schedule:

SAMPLE

PART I

HOSPITALIZATION

The purpose of hospitalization insurance is to refund an amount for each day that an insured person, due to illness or injury, spends in a hospital or a convalescence hospital upon recommendation of a physician, subject to a deductible, a percentage of refund and up to the maximum amounts indicated in the "Benefit schedule".

c) SHORT-TERM HOSPITALIZATION

The cost to stay in a hospital room as stipulated in the "Benefit schedule" in a hospital for short-term care, less the fees that are refunded or refundable by a governmental insurance plan.
Eligible short-term care includes prevention, medical diagnosis and medical treatment for acute illnesses.

d) CONVALESCENCE HOSPITAL

The cost to stay in a hospital room as stipulated in the "Benefit schedule" in a convalescence hospital, less the fees that are refunded or refundable under a governmental insurance plan, while this plan is in effect.
The insured person must be admitted within fourteen (14) days after leaving the hospital for which he was receiving short-term care or had been admitted for less than one (1) day for an operation requiring local anaesthesia. Eligible expenses are limited to a maximum period as stipulated in the "Benefit schedule".

PART II

PRESCRIPTION DRUGS

No prescription drugs are covered under this benefit.

PART III

PARAMEDICAL SERVICES

Expenses for Paramedical services, subject to the deductible, the percentage of refund and up to the maximum indicated in the "Benefit schedule", provided by a/an:

- Acupuncturist
- Chiropractor
- Dietitian
- Homeopath
- Kinotherapist
- Massage therapist *
- Naturopath
- Osteopath
- Physiotherapist *
- Podiatrist or chiropodist
- Psychologist
- Occupational therapist
- Speech-language pathologist

*Only covered if prescribed by a physician

The maximum amount and number of visits per calendar year for each above-mentioned specialist or each grouping of specialists are indicated in the "Benefit schedule".
Specialists must be members of their professional association, recognised by the insurer, and they must provide services that fall within their specialty. They must not be a member of the insured's immediate family.
In addition, eligible expenses per insured person are limited to one (1) visit per day per specialist.

SAMPLE

PART IV

OTHER EXPENSES

The following expenses, subject to the deductible, the percentage of refund and up to the maximum indicated in the "Benefit schedule", are covered on the condition that they are prescribed by a physician and are necessary for treatment of an illness or an accident and are normal and reasonable with current medical procedures:

aa) rental or purchase, whichever is deemed more economical by the Insurer of a non-motorized wheelchair, a standard hospital bed (excluding mattress) and any other equipment normally considered to be used in a hospital for the purpose of temporary treatment;

bb) The cost of oxygen, as well as the rental or purchase, whichever is deemed more economical by the Insurer, of the equipment necessary to administer it. The insured must obtain prior authorization from the Insurer before any purchase or rental. Failure to obtain this authorisation may result in the Insurer's rejection of the claim;

cc) when deemed necessary for prevention or diagnosis, the following laboratory analysis, x-ray procedures such as computer tomography (scanners), ultrasounds, electrocardiograms, mammograms, x-rays (except for teeth and orthosis) expenses subjected to a maximum indicated in the "Benefit schedule" per period of 12 consecutive months;

dd) The service of a registered private nurse outside of the hospital required after a hospitalization or surgical intervention requiring local anaesthesia performed at the hospital. The insured must obtain authorization from the Insurer for these services. The nurse must be a member of a professional association in the insured's province of residence;

ee) rental or purchase, whichever is deemed more economical by the Insurer, of the following medical supplies or equipment:

a. orthopaedic corsets and hernial trusses;

b. cervical collars;

c. walkers or other mobility aids required for temporary therapeutic use, such as crutches, canes or walking frames;

d. orthopaedic devices that help to keep a part of the body properly positioned. Elastic support bandages and foot orthoses are not covered in this category);

ff) the purchase or repair of a glycemic-control mechanism such as a glucose monitor, an insulin dosing system, a pressure insulin injector or any other approved system by the Insurer is payable upon presentation of a complete report from a physician certifying that the insured is insulin-dependant;

The insulin pomp isn't eligible under this description but under the description « Insulin Pump »

gg) expenses for the following diabetic supplies:

a. blood letting device, including platforms but excluding lancets;

b. Insulin infusion sets, excluding infusion pump;

The glucoses sensors are not eligible;

hh) expenses of an insulin pump and its accessories for type1 diabetes;

ii) when deemed necessary for prevention or diagnosis, nuclear magnetic resonance imaging, subject to a maximum indicated in the "Benefit schedule" per period of 12 consecutive months;

jj) the cost of corrective devices or the purchase of custom-made orthoses or arch supports and the cost of custom fitted orthopaedic shoes manufactured especially for the Insured person in a dedicated orthopaedic laboratory , up to the maximum amount and period indicated in the "Benefit schedule". The orthoses may also be prescribed by a podiatrist;

kk) the cost of eligible supplies that become necessary following a colostomy, an ileostomy or a urostomy;

ll) rental or purchase, whichever is deemed more economical by the Insurer, of a transcutaneous electric neurostimulator unit (tens). The insured must obtain authorization from the Insurer before making any purchase or rental. Failure to obtain this authorisation may result in the Insurer's rejection of the claim;

mm) the purchase of an IUD;

SAMPLE

nn) the purchase of reagent strips, syringes and needles for diabetics;

oo) the purchase of brassieres (following mastectomy);

pp) the purchase of elastic stockings for varicose veins or phlebitis sold by a specialized firm;

qq) pressure garment for major burns;

rr) rental or purchase, whichever is deemed more economical by the Insurer, of a Continuous Positive Airway Pressure apparatus (CPAP) or of a maxi-mist machine, including the masks.

All the following expenses are covered without being prescribed by a physician:

ss) in emergency situations that happened in the insured's province of residence, the expenses for transportation to a hospital in a duly authorised ambulance, as well as air or train transport to the nearest hospital, if the insured person cannot be transported in any other means;

tt) the purchase of optical prostheses or artificial limbs. A single optical prosthesis per eye and a single artificial limb per amputated limb is covered for the lifetime of the insured person.

uu) the purchase of external breast prostheses necessary following a mastectomy, in excess of the amount covered by a governmental plan, subject to an external breast prostheses per period of 24 months;

vv) the purchase of plaster cast;

ww) the purchase or repair of a hearing aid prescribed by an audiologist, up to the maximum amount indicated in the "Benefit schedule" per period of 36 consecutive months;

xx) the purchase of a wig required for pathological conditions or following chemotherapy treatments;

yy) the cost of sclerotherapy administered by a physician (solution only);

zz) subject to prior evaluation by the Insurer, expenses for professional services rendered by a dental surgeon to repair damage cause to natural, healthy and whole teeth in an accident that occurred while the insured person was covered under this benefit and providing that treatment is given within six (6) months of the accident providing this plan is still in effect when the care is provided and the expenses are incurred in the insured's province of residence.

Eligible expenses are determined using the amounts indicated in the suggested fee guides for dental services, in force in the province where the services are given and when expenses are incurred.

Accidental damages to the teeth that occurs while eating are excluded.

PART V

VISION CARE SERVICES

Subject to the deductible, the percentage of refund and up to the maximum indicated in the « Benefit schedule », the following expenses are covered:

4. the cost of corrective lenses and eyeglass frames or the cost of contact lenses, when prescribed by an ophthalmologist or an optometrist, up to the amount and period indicated in the "Benefit schedule". Expenses for the purchase of sunglasses or security glasses, with or without corrective lenses aren't eligible;
5. the cost of an eye examination by an ophthalmologist or an optometrist authorized, up to the amount and period indicated in the "Benefit schedule";
6. contact lenses or intraocular lenses following a cataract surgery, up to the lifetime maximum indicated in the "Benefit schedule".

OVERALL MAXIMUM

The overall maximum applicable per insured person is for Parts I, II, III, IV and V combined as indicated in the Benefit Schedule.

SAMPLE

COORDINATION OF BENEFITS

Benefits payable under this coverage are reduced in such a way that, when these benefits are added to any other benefits provided through any other insurance plan, private or public, covering the same insurable expenses, the overall benefits do not exceed the actual amount of expenses incurred.
This present plan covers the expenses exceeding all other coverages under which the insured is eligible. If the other plan or plans of the insured have a maximum eligible high enough to cover the entire claim, no benefit will be payable. This plan is the second payer.

PROOF OF CLAIM

Eligible expenses are refundable upon presentation of original receipts.
To establish proof of claim, the insured must submit to the Insurer original receipts from the suppliers providing treatments or products.
The insured must submit to a medical examination when the Insurer is justified in requesting it considering the type of treatments that are required by the insured person's state of health. In the event of a medical examination, the physician is designated and paid by the Insurer.
The Insurer may also request, at the insured's expense, a report from the health professional that is treating the insured person. The Insurer may request declarations from the person claiming benefits, as well as the use of the Insurer's forms.

SURVIVOR BENEFITS

If, at the time of the Insured's death, his or her dependents are covered by this coverage, this insurance coverage remains in force without further payment of premiums. However, this coverage ends on the first of the following date:

e) twenty-four (24) months after the Insured's death;

f) the date the spouse or a dependent no longer meets the requirements mentioned in the definition of a dependent;

g) The date that a similar coverage with another insurer goes into effect;

h) The date this benefit or contract terminates.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the insured's insurance stipulated in the section entitled "General provisions" of the present contract, the insured's insurance for this benefit will terminate on the earliest of the following dates at midnight:

d) date the Insurer receives the termination written notice from the insured or at any other later date indicated on that notice;

e) date the insured no longer meets the eligibility requirements or definition;

f) termination date indicated in the "Benefit schedule".

EXCLUSIONS

NO BENEFIT IS PAYABLE FOR LOSSES RESULTING FROM THE FOLLOWING CAUSES OR INCIDENTS:

n) the insured person's participation in a criminal act or attempted criminal act;

o) injury or illness resulting from the insured person's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not;

p) suicide or any self-inflicted wound or mutilation, regardless of the insured person's state of mind;

q) incurred expenses for treatment not medically required, or for cosmetic purposes or treatments that exceeds usual care normally applied for therapeutic purposes;

r) all expenses that are payable or refundable under any governmental insurance plan or normally would be, or private plan;

SAMPLE

s) all expenses arising from an illness or accident falling under the authority of a provincial organism of the insured's province of residence, like the CNESST or the Société de l'assurance automobile du Québec (SAAQ);

t) all expenses in excess of those considered reasonable, taking into consideration the importance of the situation, the normal rates in the region and the procedure that is normally used;

u) all treatments or services that are provided free of charge or that would be free in the absence of insurance or that are not at the insured's expense;

v) expenses incurred for a health trip, a rest cure, diet purposes or weight-loss treatments;

w) treatments or services given by a member of the insured person's immediate family;

x) medical expenses resulting from any illness or injury attributable to an occupation or employment for wages or profit;

y) expenses for varicose vein injections in the lower limbs, giving in a nonmedical purpose;

z) any drug that is available to the general public without a medical prescription;

aa) any drug that are available with a medical prescription

EXPERT MEDICAL OPINION

Any Insured covered under this insurance benefit is entitled access to a second medical opinion benefit. The current provider of this benefit is Best Doctors; however, the provider and the services offered are subject to change at UV Insurance's discretion

Best Doctors

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DENTAL CARE INSURANCE

PURPOSE OF THE DENTAL CARE INSURANCE

Provided that this coverage is in force when the insured person incurs expenses, the Insurer will reimburse eligible expenses deemed medically necessary, subject to all other provisions of the contract and in accordance with the terms of payment outlined in the Benefit Schedule.

ELIGIBILITY AND CONDITIONS

To be eligible for this coverage, the insured must be at least 16 years of age and have extended health insurance in force with the insurer.

The eligible expenses according to the present plan are those incurred for the supplies, services and treatments by the insured, not exceeding the amounts indicated in the suggested fee guides for dental services, in force when expenses are incurred, as mentioned in the "Benefit schedule", not excluded in the article "Exclusions" of the present benefit.

Expenses must be incurred in the province of residence of the insured.

ELIGIBLE EXPENSES

Expenses are eligible under this benefit provided they have been paid by the insured and are:

a) approved by the Insurer;

b) exceed the amounts refunded or refundable by any other insurance contract or governmental plan;

c) incurred by the insured for the supplies, services and treatments covered under this benefit and are foreseen in the "Benefit schedule";

d) recommended, approved and considered necessary by a dentist or a denturologist;

e) not exceeding the amounts indicated in the suggested fee guides for dental services, in force when expenses are incurred, as mentioned in the "Benefit schedule". If not mentioned in the fee guides, the expenses are limited to the amount generally requested in the province of residence of the insured for supplies, treatments or services that are comparable or similar cases;

f) incurred while the insurance is in force. Eligible expenses will be deemed to have been incurred on the day that the treatment is rendered or the products are provided. If a dental treatment requires more than one session, expenses will be deemed incurred on the date of the last session. In particular, the date of treatment for:
   1) a prosthetic device, is the date of insertion, and;
   2) a root canal treatment, is the date of the obturation of the root canal;

g) not excluded in the article "Exclusions and restrictions" of the present benefit.

BENEFIT AMOUNT

The Insurer pays, after subtracting the deductible, based on the percentage and up to the maximum indicated for this purpose in the Benefit Schedule, reasonable, usual and customary expenses for the following dental services.

SAMPLE

MAXIMUM AMOUNT

The maximum amount of reimbursable benefits is an annual maximum applicable to each insured per year of insurance and indicated in the “Benefit schedule”.

COORDINATION OF BENEFITS

Benefits payable under this coverage are reduced in such a way that when these benefits are added to any other benefits provided through any other insurance plan, private or public, covering the same insurable expenses, the overall benefits do not exceed 100% of the actual amount of expenses incurred.

This present plan covers the expenses exceeding all other coverages under which the insured is eligible. If the other plan or plans of the insured have a maximum eligible high enough to cover the entire claim, no benefit will be payable. This plan is the second payer.

INSURED’S OBLIGATION TO SUBMIT A TREATMENT PLAN

When the expected cost of material, treatment and services exceeds four hundred dollars ($400), the insured must submit, on a form provided by the Insurer, a treatment plan completed by his dentist. This treatment plan must contain all the details of the material, treatments and services to be administered as well as their approximate cost. The pre-treatment x-rays must be submitted at the Insurer’s request.

If the insured neglects to submit a treatment plan, the Insurer may evaluate the eligible benefits based on other materials, treatments or services which are acceptable under the dental norms recognised in Canada.

Expenses incurred after the insured’s insurance is no longer in force will not be reimburse even if a treatment plan was submitted to the Insurer and an evaluation of eligible benefits was given.

PROOF OF CLAIM

To establish a proof of claim, the insured must submit to the Insurer, a claim duly completed on the form provided by the Insurer.

As proof of claim, the Insurer may request details of supplies, treatments and services rendered, as well as a complete diagram showing the extractions, fillings and any other prior treatment. The Insurer may also request laboratory or hospital reports, diagnostic models, x-rays or any other justification of treatment or pathological state of the teeth or of the mouth.

If an insured refuses to submit to the examination requested by the Insurer, the payment of all benefits ceases automatically as of the date of the request.

SURVIVOR BENEFITS

If, at the time of the Insured’s death, his or her dependents are covered by this coverage, this insurance coverage remains in force without further payment of premiums. However, this coverage ends on the first of the following date:

i) twenty-four (24) months after the Insured’s death;

j) the date the spouse or a dependent no longer meets the requirements mentioned in the definition of a dependent;

k) the date a similar coverage with another insurer goes into effect;

SAMPLE

l) the date this benefit or contract terminates.

REINSTATEMENT OF THIS PLAN

If an Insured cancel this benefit or contract, he will only be eligible to the dental care insurance plan after a twenty-four (24) months period following the cancellation date.

ELIGIBLE EXPENSES

The eligible expenses under this plan are those incurred for the supplies, services and treatments as defined below:

BASIC CARE

a) **DIAGNOSTIC SERVICES**

1) **ORAL EXAMINATION**

- complete examination (or initial), subject to one examination per period of sixty (60) consecutive months, including x-rays if required;
- A recall or periodic examination, subject to one examination only for the period outlined in the Benefit Schedule and including x-rays if required;
- Specific or emergency examinations (except for orthodontic treatments).

2) **X-RAYS**

Intra-oral and extra-oral films:

- One complete series of x-ray, up to a maximum of 1 series per period of thirty-six (36) consecutive months;
- Interproximal x-ray, up to a maximum of 2 series per period of twelve (12) consecutive months;
- panoramic x-ray, up to a maximum of one (1) per period of thirty-six (36) consecutive months;
- other x-rays covered under this plan.

3) **OTHER SERVICES**

- laboratory tests and examinations;
- diagnostic casts.

b) **PREVENTIVE SERVICES**

1) tooth polishing (prophylaxis), up to a maximum of one (1) treatment per period as outlined in the Benefit Schedule;
2) topical fluoride application, up to a maximum of one (1) treatment per period as outlined in the Benefit Schedule;
3) scaling, up to a maximum of six (6) units per twelve (12) consecutive months.

c) **MINOR RESTORATIONS**

- amalgam-based restoration, using acrylic or composite;
- restauration of a post;
- restoration of primary molars, limited to the maximum of an amalgam restoration only;
- Composite restorations are covered on permanent molars only
- repair of removable or fixed prosthesis, up to a maximum of $500;
- sedative dressing.

d) **ORAL SURGERIES**

- simple and complicated extractions of teeth or residual roots;
- alveoplasty, gingivoplasty and stomatoplasty;
- surgical excision of tumours or cysts;
- repair of soft tissue laceration;

SAMPLE

- surgical incision and drainage;
- post-surgical treatment.

e) ANESTHESIA

- fees for general anesthesia used for oral and periodontal surgery up to a maximum of six (6) units per period of twelve (12) consecutive months;
- local anesthesia.

f) PERIODONTIC SERVICES

Expenses payable in this category include expenses for service considered medically necessary to treat pathological conditions affecting the bone or tissue supporting the teeth, up to a maximum of two (2) units per year:

- periodontal curettage;
- gingivoplasty,gingivectomy and mucco-gingival surgeries;
- corrective surgery to osseous defects;
- all other treatment covered under the periodontic services.

g) ENDODONTIC SERVICES

Dental care services for dental pulp diseases and periapical tissues:

- pulp capping;
- pulpotomy;
- root canal;
- periapical treatments;
- all other treatment covered under the endodontic services.

MAJOR RESTORATION SERVICES AND SURGERY

a) MAJOR RESTORATIONS

- Stump restoration;
- Pins (including retentive pins or posts; prefabricated or cast);
- Restoration of inlay or application of a crown only if the tooth broke due to cavities and cannot be restored with amalgam, acrylic, or composite restorations;
- Gold caps only in circumstances where the tooth cannot be restored with other materials.

b) ORAL SURGERY

Includes dental services related to the treatment or fractures and diverse extensive surgeries.

- repositioning or transplanting;
- osteoplasty;
- lowering of the mouth floor;
- fracture reduction;
- frenectomy;
- mandibular dislocation;
- other extensive surgeries;
- post-surgical treatment.

PROSTHETICS

a) REMOVABLE PROSTHESIS

1) INITIAL PROSTHODONTIC APPLIANCE

Expenses for initial placement or replacement of a full or partial removable prosthesis if the purpose of the replacement is to replace one or more natural teeth that were extracted while the insured person was covered under the current coverage.

2) REPLACEMENT OF REMOVABLE PROSTHESIS

Expenses for replacement of complete or partial prosthesis are eligible if:

- The purpose of the replacement is to replace one or more natural teeth that were extracted while the insured person was covered under the current coverage;
- The prosthesis has been in place for at least sixty (60) months and has become non-functional.

3) TRANSITIONAL PROSTHESIS

SAMPLE

The prosthesis already in place is an immediate temporary prosthesis that must be replace by a permanent prosthesis within twelve (12) months of the date the immediate temporary prosthesis is put in place.

b) FIXED PROSTHESIS

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1) FIX BRIDGE

- Expenses for a fix bridge to replace one or several natural teeth that were extracted while the insured person was covered under the current coverage following restrictions:
  - the fix bridge is replacing one or several natural teeth, and at least one tooth was extracted while the insured person was covered under the current coverage;
  - the fix bridge has been in place for at least 60 months and has become non-functional.

2) REPAIR OF FIXED PROSTHESIS

- Repair of crowns and of fixed bridges.

EXCLUSIONS AND RESTRICTIONS

No benefits are payable under this coverage for the following causes or events:

a) the insured's participation in a criminal act or attempted criminal act;

b) injury or illness resulting from the insured person's active participation in a civil commotion, riot, insurrection or military operation, whether war is declared or not;

c) injury or illness resulting from self-inflicted injuries, regardless of the insured's state of mind;

d) expenses incurred resulting directly or indirectly from driving while being under the abusive consumption of drugs or alcohol;

e) all expenses payable or refundable under any governmental plan or that would normally have been payable;

f) expenses incurred for treatment not medically required, or for aesthetic purposes or treatment that exceeds usual care normally applied for therapeutic purposes;

g) expenses for treatments or services incurred before the insured's effective date of insurance;

h) expenses charged for travelling, cancelled appointments, telephone consultations or completion of forms requested by the Insurer;

i) expenses for appliances normally worn for sports;

j) expenses that are not covered under a governmental plan, but would usually be, just because the dentist is considered as a non-participating professional member under the plan;

k) all treatments or services administered free of charge or that an insured does not have to pay for;

l) treatments eligible for refund under the health insurance benefit of the present contract;

m) all dental care expenses resulting from any illness or injury attributable to an employment or occupation for wages or profit;

n) Expenses for dental care incurred for complete reconstruction of the mouth or correction of vertical dimension;

o) treatment relating to temporomandibular joint or dental implants;

p) expenses for orthodontic treatment, including diagnostic services, extractions or other services necessary;

q) expenses incurred in relation to dietary analysis, recommendations, oral hygiene instructions or dental plaque control programs;

r) expenses incurred for pre-surgical or post-surgical treatment, when given in a hospital;

s) Basic services expenses under this present plan do not apply for:

1) the completion of fillings, other than at the time of the filling;

SAMPLE

2) anaesthesia used for the treatment of fractures and dislocation of the mandible or used for any treatment not covered under this plan;

3) the installation and purchase of a removable prosthesis;

4) the purchase, installation and repair of a fixed prosthodontic;

t) Restauration and complex surgeries expenses under this present plan do not apply for gold or porcelain covering of bridges or crowns after the second molar;

u) Prosthodontic expenses under this present plan do not apply for:
1) expenses for replacement of lost, misplaced, stolen or reparable prostheses;
2) personalized or duplicate prosthesis.

In addition, when more than one treatment can be administered with the same clinical result, refund is limited to the least expensive treatment covered under the contract.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the insurance benefit stipulated in the section entitled "General provisions" of the present contract, the insurance for this benefit will terminate on the earliest of the following dates at midnight:

g) date the Insurer receives the termination written notice from the insured or at any other later date indicated on that notice;

h) date the insured no longer meets the eligibility requirements or definition;

i) termination date indicated in the "Benefit schedule".

SAMPLE

TRAVEL INSURANCE BENEFIT

PURPOSE

The purpose of this benefit is to reimburse eligible expenses incurred by the insured person as a result of illness or accident that occurs outside his province of residence, in accordance with the terms and conditions stipulated in the Benefit Schedule, provided the travel insurance coverage is in force.

The insurer, in collaboration with the medical assistance service provider and its coordination centres, also offers certain medical assistance services in the event of an emergency outside the insured's province of residence.

The expenses and services described in this section are complementary to those covered by the health insurance plan of the insured's province of residence or any other government insurance plan, provided these expenses are not excluded under the "Limitations, Restrictions and Exclusions" section herein. This travel insurance does not replace them.

ELIGIBILITY AND CONDITIONS

Only persons under the age of 70 who are covered under the government hospitalization and health care plan in their province of residence for the entire trip are eligible for travel insurance coverage.

Insured persons are eligible for this coverage while travelling outside their province of residence for a maximum number of consecutive days as stipulated in the Benefit Schedule. Trips separated by a return trip to the insured's province of residence of less than 72 hours shall be considered as a single trip with respect to the number of consecutive days allowed.

To be eligible for this coverage during a trip that exceeds the maximum consecutive days of coverage stipulated in the Benefit Schedule, the insured person must extend his coverage with another travel insurance contract. If the totality of the trip is not insured, the insured person will not be covered under this insurance from the first day of coverage.

This insurance covers eligible expenses, on a usual and customary basis consistent with standard practice, incurred in an emergency outside the province of residence in excess of expenses payable under any government plan.

DEFINITIONS

a) BUSINESS ASSOCIATE

The individual with whom the insured is associated for business purposes as part of a company comprised of four (4) or fewer co-shareholders, or a non-commercial company comprised of four (4) or fewer associates.

b) TRAVELLING COMPANION

The individual with whom the insured shares a room or apartment at destination, or whose expenses have been paid with those of the insured.

c) TRAVEL EXPENSES PAID IN ADVANCE

SAMPLE

Expenses incurred by the insured person for the purchase of a travel package, a ticket from a public carrier or for the rental of a motorized vehicle from an accredited agency.

d) HOSPITALIZATION

Refers to an admission to hospital for a period of at least 18 hours for emergency medical care or surgery that is not cosmetic in nature.

e) HOSPITAL

Means a short or long-term clinic as established by the laws in force, excluding extended health care centre.

Centres that are reserved for youths, a clinic for people with a mental deficiency or with tuberculosis, a sanatorium, a nursing home, a rehab centre, centres offering respite care for physically or mentally challenged persons or centre offering keeping care are not considered a hospital.

f) HOST AT DESTINATION

The person whose principal residence is to be used as accommodation for the insured based on an agreement made in advance.

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ELIGIBLE EXPENSES

For each person covered under this benefit, subject to a deductible and coinsurance, up to the maximum amounts indicated in the Benefit Schedule, the insurer shall reimburse the following expenses in excess of those payable by any government plan that were incurred outside his province of residence:

a) Emergency hospitalization expenses incurred outside the insured's province of residence up to the cost of a semi-private room (with two beds);

b) Doctors' fees incurred in the event of a medical emergency;

c) Emergency expenses incurred for the following services, provided they are prescribed by a physician:

a. prescription drugs required following a medical emergency;

b. the cost of diagnostic services when deemed necessary for preventive or diagnostic purposes;

c. the cost of renting a basic model wheelchair, crutches, canes or walkers required temporarily for therapeutic purposes following an accident or illness;

d. in case of an emergency, the cost of transportation to a hospital by an ambulance duly authorized for this purpose, as well as transportation by train or plane to the nearest hospital if the person cannot be transported by other means;

e. if the insured person travelling alone dies, or is hospitalized for seven (7) consecutive days or more, the medical assistance service will make the necessary travel arrangements based on the most economical round-trip, to have a family member visit the insured at the hospital where he is staying, or to identify the deceased before transporting the remains. These costs are limited to one thousand five hundred dollars ($1,500) and to one visitor only;

f. the cost of returning the personal vehicle of an insured person travelling alone who is unable to use it as a result of accident or illness. The medical assistance service will organize and settle the return of the vehicle to the insured's residence. These expenses are limited to seven hundred and fifty dollars ($750);

g. in the event of death of the insured person, the medical assistance service will take care of all the necessary documents and arrange for the transportation of the deceased's remains to the insured's province of residence. In this case, reimbursable expenses are limited to three thousand dollars ($3,000), excluding embalming, coffin and funeral expenses.

SAMPLE

h. if, following an insured person's hospitalization for a period of more than twenty-four (24) hours, or his death, expenses for accommodation and meals incurred by the insured or his travelling companion because the return is postponed or when a family member visits. Such expenses are reimbursed up to one hundred and fifty dollars ($150) per day, up to a maximum of one thousand fifty dollars ($1,050) for all persons covered. Only expenses incurred after the scheduled date of return are covered.

i. if an insured person is hospitalized or dies and his accompanying children are left without supervision, the necessary arrangements will be made to organize supervision and arrange for tourist class transportation for the children, accompanied if necessary, to their place of residence in Canada. If the children's travel tickets have not expired, only the return ticket supplement will be reimbursed. However, if the travel tickets have expired, the necessary arrangements will be made for return transportation, using the most economical means. This cost is limited to two thousand dollars ($2,000) for all children.

j. dental fees incurred following an accident to natural teeth, up to a maximum of one thousand dollars ($1,000).

k. the most economical additional cost charged by a public carrier (train, bus or air line) when the illness requires the insured person to be accompanied by a medical assistant (other than the travelling companion, family member or a person with whom he resides) for the return to his province of residence:

   i. a return ticket to the province of residence for the insured person and a round-trip ticket for the medical assistant; or

   ii. if a stretcher is required, the cost of additional seats needed for the stretcher and a round-trip ticket for the medical assistant.

EMERGENCY MEDICAL ASSISTANCE SERVICES

a) TELEPHONE SERVICE

Toll-free telephone access to coordination centres, twenty-four (24) hours per day and seven (7) days per week, for the multilingual assistance services described herein, in the event of an emergency while the insured person is travelling outside his province of residence.

b) MEDICAL ASSISTANCE

Following an accident or sudden illness, if the insured person must consult a physician or be hospitalized, he must immediately call the medical assistance service which will make the necessary arrangements in order to provide the following services:

- In the state of Florida, direct the insured person to an appropriate clinic or hospital that is a member of the Preferred Patient Care network;
- For all other destinations, direct the insured person to an appropriate clinic or hospital and advance funds to the hospital, if necessary;
- Confirm medical insurance coverage so that the insured person does not have to pay a substantial deposit;
- Follow up on the medical file and communicate with the family physician;
- Coordinate the insured person's claims with the various government plans of his province of residence.

c) MEDICAL TRANSFER

Following the recommendation and to the sole discretion of the physician designated by the medical assistance service, in consultation with the local attending physician when it is necessary to transfer the insured person to another hospital or treatment centre, or to repatriate him to his province of residence for treatment, the medical assistance service will make the necessary arrangements and pay the cost of the transfer under proper medical supervision. Any refusal to repatriate will terminate the insurance and a termination notice to the insured will be sufficient.

The decision as to the necessity of transferring or repatriating an insured person is a medical decision that is the sole responsibility of the physician designated by the medical assistance service.

The decisions regarding the means or dates of any transfer, medical appliances, medical supplies, medical staff to be used for the transfer and the final destination of the insured person are also considered medical decisions that are the responsibility of the physician designated by the medical assistance service.

SAMPLE

TRIP CANCELLATION

a) CONDITIONS

To be eligible, expenses covered under the insured's trip cancellation insurance must meet the following conditions:

1) they are paid in advance by the insured person while this coverage is in force;

2) when the trip arrangements are finalized, the insured person is not aware of any event that could reasonably lead to the cancellation or interruption of the planned trip;

3) this coverage is in force for the duration of the planned trip period.

b) ELIGIBLE CAUSES OF CANCELLATION OR INTERRUPTION

The trip must be cancelled or interrupted for one of the following causes:

1) An illness or accident preventing the insured person, a member of his immediate family, his travelling companion or his business associate from travelling that would jeopardize the company by his absence, and must be reasonably serious to justify the cancellation or interruption of the insured person's trip. If several insured persons travel together, a maximum of three (3) insured persons may be reimbursed if the cancellation or interruption is caused by the travelling companion or business associate;

2) The death of the insured person, a member of his immediate family, his travelling companion or his business associate. The funeral must take place during the planned travel period or in the fourteen (14) days preceding it;

3) The death or emergency hospitalization of the host at destination;

4) The quarantine of the insured person or his travelling companion, unless it ends more than seven (7) days before the planned date of departure;

5) An advisory to avoid all non-essential travel (level 3) or all travel (level 4) is issued by the Government of Canada for the country of destination. This recommendation must be in effect for the planned period of the trip and be issued after the insured person has finalized his travel arrangements;

6) A departure missed due to a delay in the means of transportation used to get to the departure point or the departure point for a connection after the scheduled departure. The means of transportation used must provide for planned arrival at the departure point at least 3 hours before the departure. The delay must be caused either by mechanical problems (except those related to a private automobile), a traffic accident or an emergency road closure. These last two causes must be substantiated by a police report;

7) Weather conditions delaying the departure of the public carrier used by the insured person at the scheduled departure point by at least 30% (minimum 48 hours) of the total duration of the trip, or preventing the insured person from making a scheduled connection with another carrier provided that this connection is delayed by at least 30% (minimum 48 hours) of the total duration of the trip.

c) ELIGIBLE EXPENSES

1) IN THE EVENT OF CANCELLATION PRIOR TO DEPARTURE

a) non-refundable portion of travel expenses paid in advance;

b) additional expenses incurred by the insured who decides to travel alone should his travelling companion have to cancel his trip due to one of the reasons provided for under this coverage. These expenses are reimbursable up to the amount of the cancellation penalty applicable at the time the travelling companion has to cancel;

c) the non-refundable portion of the travel expense paid in advance, up to 70% of the said expense if the departure is delayed due to weather conditions and the insured decides not to proceed with the trip.

2) IN THE EVENT OF MISSED DEPARTURE OR TRIP INTERRUPTION

SAMPLE

The additional cost charged by a scheduled public carrier (train, bus, or airline) for a one-way ticket by the most economical means of transportation via the most direct route to the initially planned destination.

The departure must be missed due to the delay of the transportation means used by the insured as described in paragraph 7) under the **ELIGIBLE CAUSES OF CANCELLATION OR INTERRUPTION** section.

The trip must be temporarily interrupted due to an illness or accident sustained by the insured or his travelling companion, as stipulated in paragraph 1) under the **ELIGIBLE CAUSES OF CANCELLATION OR INTERRUPTION** section.

3) IN THE EVENT OF A DELAYED OR ADVANCED RETURN

a) the additional cost charged by a scheduled public carrier (train, bus or airline) for a one-way ticket by the most economical means of transportation, via the most direct route to the initially planned destination. These expenses must be pre-approved by the insurer;
b) the unused and non-refundable portion of the land portion of travel expenses paid in advance.

If the insured's return is delayed by more than seven (7) days following illness or accident sustained by the insured or his travelling companion, the expenses incurred are eligible provided the person concerned was hospitalized as an inpatient for more than 48 hours within the 7-day period.

d) DEADLINE FOR REQUESTING CANCELLATION

In the event of cancellation before departure, the trip must be cancelled with the travel agency or the carrier within a maximum of 48 hours, or if it is a holiday, the next business day. The insurer must be notified at the same time.

The insurer's liability is limited to the cancellation fees stipulated in the travel contract 48 hours after the date on which the cause for cancellation occurs, or on the first business day if it is a holiday.

However, this limitation does not apply if the insured or his travel companion demonstrates to the insurer's satisfaction that they were totally and absolutely unable to act. In that case, the trip must be cancelled as soon as one of these people is able to do so. The insurer's liability is limited to the cancellation fees stipulated in the travel contract on that date.

EXTENSION OF COVERAGE FOR SURVIVING SPOUSE OR DEPENDENT CHILD

If, at the time of the insured's death, his spouse or dependent children are insured under this coverage, the spouse's insurance or the dependent child's insurance is maintained in force without the payment of premiums, until the first of the following dates:

m) Twenty-four (24) months after the date of death of the insured;

n) The date on which the spouse or the dependent child no longer meets the eligibility criteria or the definition thereof;

o) The date on which similar insurance coverage with another insurer takes effect;

p) The date on which this insurance coverage or contract terminates.

REDUCTION IN COVERAGE DUE TO COORDINATION OF BENEFITS

If an insured is entitled to similar benefits under another insurance contract or any other insurance coverage under a private or public plan, the benefits payable by the insurer are adjusted so that the total amount paid or payable under all contracts does not exceed 100% of the eligible expenses under this insurance coverage.

SAMPLE

This Benefit covers expenses in excess of all other expenses paid by other insurance plan(s) for which the insured may be eligible. If the insured's other plan(s) have a coverage ceiling high enough to cover the entire claim, no benefit shall be paid. With regards to this Benefit, the Insurer is the second payer.

TERMINATION OF INSURANCE

In addition to the reasons for insurance termination stipulated in the "General provisions" section of the contract, the coverage of an insured under this insurance terminates at midnight on the first of the following dates:

j) The day the insured person reaches age 70;

k) The date on which the insurer receives a written notice of termination from the insured or any later date indicated on such notice;

l) The date on which the insured person no longer meets the eligibility criteria or the definition thereof;

m) The termination date indicated in the Benefit Schedule.

LIMITATIONS, RESTRICTIONS AND EXCLUSIONS

LIMITATIONS

a) This insurance covers eligible expenses based on usual and customary expenses in accordance with standard practices incurred in the event of emergency outside the province of residence.

b) The expenses payable are limited to maximum amounts provided for in the Benefit Schedule.

c) Trips separated by a return to the province of residence for less than 72 hours shall be considered a single trip for the purpose of the number of consecutive days allowed.

d) The expenses payable may be reduced if the insured person or the person accompanying him does not notify the insurer as soon as possible that an event has occurred.

e) For Trip Cancellation, the insurer's liability is limited to the cancellation costs stipulated in this contract 48 hours after the date of the cause of cancellation or the first following working day if it occurs during a statutory holiday.

RESTRICTIONS

a) The insurer and the medical assistance services are not responsible for the availability or quality of medical and hospital care received, nor for the impossibility of obtaining such care or services.

b) The medical assistance service reserves the right to interrupt, shorten or restrict travel assistance services in any part of the world in the event of rebellion, riot, military insurrection, war, labour dispute or strike, nuclear accident, natural disaster, or in the event that the authorities of the country visited refuse the medical assistance service the right to offer services. Nevertheless, the medical assistance service will do everything possible to provide services during any such eventuality.

c) In the absence of medical contraindications, the insurer may require repatriation of any insured or his transfer to a different medical facility. The insured person's refusal of repatriation shall terminate the insurance coverage and a notice of termination to the insured shall be sufficient.

d) No expenses shall be paid and no assistance shall be provided to the insured by the insurer or the medical assistance service when expenses are incurred during a trip in the insured's province of residence.

SAMPLE

EXCLUSIONS

No expenses are payable for care related to a medical condition for which, in the ninety (90) days preceding the departure date, unless it is established to the satisfaction of the insurer that the condition has been stabilized, the insured person has:

- been hospitalized;
- received or was prescribed medical treatment;
- consulted a physician;
- had a change in medication, its dosage or use.

Expenses incurred during a trip that exceeds the number of days of coverage provided for in the Benefit Schedule, shall not be covered by this insurance from the first day if the insured person does not top up his coverage with another travel insurance contract to cover the total duration of the trip.

Also, no benefits are payable for loss arising from the following causes or events:

bb) Expenses incurred for and while travelling in a country or region covered by the Government of Canada's travel advisory to avoid all non-essential travel (level 3) or to avoid all travel (level 4), issued prior to the date of departure;

cc) The insured person's (or in the case of trip cancellation, his travelling companion's) participation or attempted participation in a criminal act or a riot;

dd) Any accident or illness resulting from a public confrontation, a riot, insurrection or war or act of war, whether war is declared or not;

ee) The insured person's participation in an aerial flight in any capacity other than that of a paying passenger on a regular or chartered flight;

ff) Suicide or any injury or damage that the insured inflicts on himself, whether sane or insane;

gg) Training maneuvers of the armed forces;

hh) Expenses incurred for pregnancy, miscarriage, childbirth or any related complications occurring when the gestation period is 32 weeks or more;

ii) The insured suffers bodily injury while driving a vehicle under the influence of alcohol or drugs;

jj) The insured's participation in any sport or any dangerous activity such as but not limited to: land or water motor vehicle racing, scuba diving, hang-gliding or parasailing, mountain climbing, parachute jumping (free fall or not), bungee jumping, back-country snow sports, combat sports, or any other similar dangerous activity or sport. In general, the sports considered dangerous are extreme, with contact, or adventure sports. These sports can occur on the sea, in the air or on land. They usually involve speed, specialized equipment, stunts or physical contact and carry a higher risk of accident or injury.

kk) No expenses are paid for elective or non-emergency surgery or treatment if the trip outside the insured's province of residence is undertaken with the intention of receiving medical treatment or hospital services, whether or not the trip is undertaken on the recommendation of a physician;

ll) Expenses incurred for care that is not medically necessary, or provided for cosmetic purposes, or care that goes beyond ordinary care;

mm) All expenses payable or reimbursable or that would normally have been payable or reimbursable under any government insurance plan or private insurance plan;

nn) All expenses in excess of what is reasonable, given the seriousness of the case, normal rates in effect in the region and the procedures normally used;

oo) All care and services provided by a third party or which would be provided in the absence of insurance;

pp) Services, care or products administered for experimental purposes;

qq) Any care or services provided free of charge or that would be free of charge in the absence of insurance or that are not at the insured's expense;

SAMPLE

rr) expenses incurred for a health trip, a rest cure, diet purposes or weight-loss treatments;

ss) Expenses incurred for care or services provided by a member of the insured's immediate family;

tt) Medical expenses arising from any illness or injury attributable to an occupation or employment for wages or profit;

uu) The cost or routine examination or medical check-up or any expense incurred in connection with a medical examination or medical treatment for purposes other than curative;

vv) Any drugs available over the counter (GP products) not requiring a medical prescription;
ww) Expenses incurred without the prior approval of the insurer;
xx) Administrative fees for the completion of documents;

yy) Any claims received after the earliest of the following dates:

a. more than 12 months after the date on which the expenses were incurred;
b. more than 90 days after the date on which the policy terminated, regardless of the service date;

Specific additional exclusions applying to trip cancellation insurance

No benefits are payable for loss resulting from the following causes or events:

1) The insured person knew the reason that would prevent him from undertaking or completing the trip at the time of purchase or on the departure date;
2) The reason given does not prevent, beyond any reasonable doubt, the insured person from undertaking or completing the trip;
3) The trip is undertaken with the intention of receiving medical treatment or hospital services, whether or not the trip is undertaken on the recommendation of a physician;
4) For persons aged between 61 and 70, whose trip does not exceed 45 days, and for persons aged 60 or less, where the illness or injury incurring expenses is related to a medical condition for which the person has already consulted a physician, been under treatment, taken medication or been advised to do so in the 3 months preceding the purchase of the trip, or the date of departure. This restriction does not apply if this medical condition began more than 3 months before the purchase of the trip or the date of departure and has remained stable or under control during these 3 months;
5) For persons who are aged between 61 and 70, and whose trip lasts 46 days or more, if the illness or injury incurring expenses is related to a medical condition for which the person has already, during the 12-month period preceding the purchase of a trip or the date of departure:

- consulted a physician;
- undergone treatment;
- taken medication or was advised to do so.

This restriction does not apply if the medical condition giving rise to expenses:

- began more than 12 months before the purchase of the trip or date of departure;
- has remained stable and under control during the 12 months preceding the purchase of the trip or the date of departure; and
- if it is not one of the following medical conditions:

1. chronic obstructive pulmonary disease
2. heart attack
3. angina
4. stroke
5. malignant tumour

However, the medical conditions listed above are not taken into consideration if they began more than 36 months before the purchase of the trip or the date of departure, and have remained stable and under control over the past 36 months;

SAMPLE

6) The trip is undertaken for the purpose of visiting a person who is ill or has suffered an accident, and the cancellation or interruption of the trip results from the death or deterioration of the medical condition of that person;

7) At the time of finalizing the travel arrangements, the insured person is aware of an event that could reasonably give rise to the planned trip's cancellation or interruption;

8) The insured's ingestion of toxic quantities of medication, alcohol or drugs;

9) Pregnancy, miscarriage, childbirth or related complications when these expenses are incurred within 12 weeks of the expected date of delivery.

NOTICE AND PROOF OF CLAIM

The insured person must submit to the insurer (if coverage is still in force) the required proof within 12 months of incurring the expenses.

The fees incurred in obtaining proof deemed satisfactory to the insurer are at the expense of the insured.

The insured person who disagrees with the insurer's decision may appeal it in writing within 30 days of that decision.

No request for review will be considered if it is received more than 30 days after the insurer's decision.

Upon termination of the policy, all claims for incurred expenses must be received by the insurer no later than 90 days after the termination date, regardless of the service date, otherwise they will not be admissible.

SAMPLE

HOME CARE ASSISTANCE

The use of masculine nouns and pronouns in this rider is assumed to include the feminine equivalents. The same is true of the singular and plural.

SCOPE

Provided that this coverage is in force on the day an Insured is considered functionally dependant and incurs expenses, the Insurer shall reimburse, in accordance with the settlement terms indicated in the Benefit Schedule and all other provisions of the contract, the eligible expenses described below.

CONDITIONS AND ELIGIBILITY

This coverage provides for the reimbursement of expenses incurred for the services, supplies, and medical care described in the "Eligible expenses" section, subject to the applicable limitations and exceptions.

This coverage is not intended to replace the health insurance plan of the province in which the Insured resides or any other government health insurance plan.

To be eligible for this benefit, the Insured must be between 18 years of age and 69 years of age inclusively at signing of application. The maximums indicated for this benefit are per Insured and are specified in the Benefit Schedule.

DEFINITIONS

In this rider, unless otherwise specified:

Activities of daily living definition:

(a) **Bathing** means washing with or without the aid of assistive devices in a bathtub or shower, including getting in and out of the bathtub or shower, or by sponge bath.
Bathing doesn't include the ability to reach and wash the back or feet.

(b) **Dressing** means putting on, taking off, fastening and unfastening, with or without the aid of assistive devices: clothing, and medically necessary braces or artificial limbs. An Insured is not functionally dependent for dressing if reasonable alterations to or changes in the clothing the Insured usually wears would let the Insured dress himself or herself without substantial physical assistance.

(c) **Toileting** means getting to and from and on and off the toilet, with or without the aid of assistive devices, and performing associated personal hygiene.

(d) **Transferring** means moving into or out of a bed, chair or wheelchair, with or without the aid of assistive devices.

(e) **Feeding** means consuming food or drink that has been prepared and served, with or without the use of assistive utensils.

(f) **Continence** means the ability to control either bladder or bowel functions, or maintain a reasonable level of personal hygiene (including caring for catheter or colostomy bag) when not able to control bowel or bladder functions.

Benefit Schedule means the Benefit Schedule attached to this rider.

Consultation takes place when the Insured is referred by a health professional for an appointment with another health professional who can make recommendations or provide an opinion because he or she has expertise that is pertinent to the case.

Functionally dependent means that the Insured is unable to accomplish two or more activities of daily living or has a deteriorated mental ability or needs stand-by assistance to perform bathing or transferring. To be considered functionally dependent, the Insured must also, if applicable, follow recommended treatments made by a health care professional.

Deteriorated mental ability (cognitive impairment) means that continuous supervision by another person is needed for protection from threats to physical health and safety as the result of deterioration in or loss of:

- Short-term memory;
- Orientation as it relates to people, place and time;
- Reasoning or

SAMPLE

- Judgment as it relates to safety or awarenes

SAMPLE

Deteriorated mental ability must result from an organic brain disorder such as Alzheimer's disease, irreversible dementia, or brain injury. Diagnosis must be made by physician.

Eligible expenses are those costs incurred by the Insured for medical supplies or services that are considered to be refundable because they:

(a) Are reasonable, usual, and customary expenses;
(b) Have been recommended, approved, or prescribed by a health professional;
(c) Have been approved by the Insurer;
(d) Exceed the amounts refunded or refundable by another Insurer or government plan;
(e) Have not been provided by a person who lived with the Insured prior to the Insured being functionally dependent or who is part of his or her immediate family, who is his or her business partner or who is his or her employer;
(f) Were incurred while this coverage was in force.

Facility means a long-term care centre offering residential, assistance, support, supervisory and psychological services for Insured suffering a loss of functional or psychological autonomy.

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

Health professional means any person who is legally licensed to practice a profession that involves the administration of medical services. Health professionals include physicians, pharmacists, dentists, nurse practitioners and any other professional approved by the Insurer.

Home Care means health and personal care services received outside a facility. Home care means the Insured is functionally dependent and residing in a private residence or a location that does not meet the definition of facility in this contract.

Informal caregiver means a nonprofessional person who provides care and/or support to a family member, friend, neighbour who is functionally dependent.

Injury means bodily harm or damage caused by an accident, directly and independently of any other cause.

Lifetime maximum means the overall maximum applicable per Insured as indicated in the Benefit Schedule.

Maximum amount of coverage means the amount of coverage available for a specified period for each Insured as indicated in the Benefit Schedule.

Private nurse means any registered nurse or a licensed practical nurse who is a member in good standing of his or her respective professional association.

Personal support worker means any certified personal support worker who is a member in good standing of his or her respective professional association.

Reasonable, usual, and customary expenses are fees or charges that do not exceed the amounts generally charged by other professionals, similar health care establishments, or pharmacies in the same jurisdiction for identical or comparable care, services, or supplies. These amounts are set annually or more often by the Insurer.

Stand-by assistance means another person must always be within arm's reach so you can safely and completely perform the activities of bathing and transferring. If you require stand-by assistance for only one of bathing or transferring, you are considered functionally dependent when you also require substantial physical assistance to perform one of the other activities of daily living.

You and **your** refer to the Insured under this rider.

We, **us** and **our** refer to the Insurer under this contract.

SAMPLE

ELIGIBLE EXPENSES

Provided that this coverage is in force on the day the functionally dependent Insured (who is not residing permanently or temporarily in a facility), incurs expenses, the Insurer will pay based on the maximums indicated for this purpose in the Benefit Schedule, the following reasonable, usual and customary expenses:

Monitoring system

Cost of a medical alarm system which consists of an emergency wireless transmitter, with a base station, which is connected to the telephone and contains a very sensitive microphone and loud speaker, up to the maximum indicated in the Benefit Schedule.

Moving allowance

Cost for relocation expenses that the Insurer will pay the Insured to move from his residence to a long-term care facility, up to the maximum indicated in the Benefit Schedule.

Meals

Cost for preparing meals cooked outside the residence of the Insured, up to the maximum indicated on the Benefit Schedule.

Respite

Cost for respite care for the Insured to allow the informal care giver respite and time off, up to the maximum indicated in the Benefit Schedule.

Transportation expenses

Cost for transportation of the Insured to receive care or medical follow-up. If the Insured is transported by a private car, the allowance is $0.35/km or the cost of a taxi, up to a maximum of $50 per day and up to the maximum indicated in the Benefit Schedule.

Informal caregiver support

Cost for the consultation of a specialist that provides psychosocial support to the informal caregiver in his daily duty and involvement with the Insured up to the maximum indicated in the Benefit Schedule.

Private nurse or personal support worker

The professional services of a registered private nurse, or a personal support worker from an agency specializing in home care, who is a member in good standing of his or her respective professional association, up to the maximum amount indicated in the Benefit Schedule.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the insured's insurance stipulated in the section entitled "General provisions" of the present contract, the insurance of an Insured terminates automatically upon the earliest of the following dates:

(a) The date that the Insurer receives written notice from the Insured to this effect or on any later date mentioned in said notice;

(b) The date the Insured no longer meets the eligibility requirements or definition;

(c) The termination date indicated in the Benefits Schedule;

(d) The date of death of the Insured;

(e) The date the lifetime maximum indicated in the Benefit Schedule is reached;

(f) The termination date of the Extended Health insurance benefit under this contract.

SAMPLE

COORDINATION OF BENEFITS

Expenses are only paid in excess of those payable under another insurance plan or those payable under any other benefits in this contract. When expenses are added to any other benefits provided through other insurance plans covering these same insurable expenses or through any other benefits in this contract covering these same insurable expenses, the overall benefits do not exceed the true amount of expenses incurred.

EXCLUSIONS

No benefits are payable under these coverages for expenses incurred following:

(a) Self-inflicted injuries or physical or mental damage;

(b) The commission of or an attempt by the Insured to commit a criminal act;

(c) Injuries sustained by the Insured during active participation in a civil commotion, a riot, an insurrection, or a military action, whether war has been declared or not;

(d) Alcohol or drug abuse, or use of illegal drugs;

(e) Driving a motor vehicle when the Insured blood alcohol level exceeds 80 milligrams of alcohol per 100 milliliters of blood, or exceeds the legal limit permitted by law;

(f) Inhalation by the Insured of toxic gases, unless this inhalation occurs in the ordinary course of the Insured's employment;

(g) Suicide or attempted suicide by the Insured, whether or not the Insured was of sound mind at the time.

No benefits are payable for a functionally dependent Insured who resides outside Canada or the United States.

No benefits are payable when the Insured resides in a facility.

CLAIM PAYMENTS AFTER YOUR RIDER ENDS

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

SAMPLE