Assumption Life
Group Insurance

New Brunswick Association of Nursing Homes

ALL OTHER ELIGIBLE EMPLOYEES

Contract Number: 09775
Effective Date: March 1, 2004
Prepared on: September 14, 2017

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

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

Assumption Life
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1-888-869-9797

Create your Assumption Life Group Insurance eProfile™ account

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

- Active benefit card
- Valid email address

Visit www.claimsecure.com

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

Click Register Now , then Start

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

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

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

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

You have now created your eProfile™.

Access your eProfile™ account from your smartphone.

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2. Choose benefit type
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4. Submit claim

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SCHEDULE OF BENEFITS

PLAN 09775

GROUP LIFE INSURANCE

Amount of life insurance	$50,000
Maximum amount of insurance	$50,000

Benefits will be reduced to:

$25,000 when the participant reaches 65 years of age.

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

a. on the participant's 70th birthday
b. the date of the participant's retirement
c. the date on which the insurance terminates

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

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

- When an employee is eligible and has been approved for Life waiver of premium under the NBANH Group Life Benefit plan, the approved claimant's health benefit premiums will be waived.

- If an employee has not been actively at work due to illness or injury for more than 2 consecutive years and has not applied or has been denied the Life waiver of premium benefit, the employee will no longer be eligible for health and dental benefits under NBANH.

A written request to this effect, as well as evidence of total disability deemed satisfactory shall be sent to the insurer. We do recommend that the paper work be sent in when the employee has been out on leave for four months, this is to allow enough time for the disability claims department to evaluate and review the medical file and render their decision.

OPTIONAL LIFE INSURANCE

Amount of optional life Insurance	$200,000
Proof of insurability required for amounts exceeding	$25,000

New employees have access to $25,000 of optional life coverage without having to complete medical evidence provided they apply for the optional life coverage within 45 days following their effective date of eligibility.

The amount of additional life insurance cannot be in excess of $200,000 or lower than $10,000.

Benefits will terminate upon the earliest of the following:

a. on the participant's 65th birthday
b. the date of the participant's retirement
c. the date on which the insurance terminates

Waiver of Premium
If, prior to his or her 65th birthday, a participant becomes totally disabled and remains totally disabled without interruption for at least 6 months, the insurer waives collection of any future premiums for this coverage for as long as the total disability continues.

DEPENDENT LIFE

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

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

a. on the participant's (insured employee's) 65th birthday
b. the date of his/her retirement
c. the date on which his/her insurance terminates

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

Waiver of Premium
If, prior to his or her 65th birthday, a participant becomes totally disabled and remains totally disabled without interruption for at least 6 months, the insurer waives collection of any future premiums for this coverage for as long as the total disability continues.

HEALTH CARE INSURANCE

Drug Plan

Direct-payment with pay-direct card	Plan AGM (Mandatory Generic)
Co-payment	Dispensing Fee plus 10% plus an out of pocket maximum of $2,500 annually; 100% coverage thereafter.

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

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

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

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

Drugs and Compounds refer to those drugs and compounds listed in the most up-to-date edition of the *Compendium of Pharmaceuticals and Specialties* that are:

a) approved as benefits by Assumption Life;
b) approved for use by Health Canada;
c) assigned a drug identification number (DIN) in Canada;
d) considered prescription requiring or life sustaining as approved by Assumption Life;
e) prescribed by a Health Care Professional who is licensed to prescribe under the appropriate provincial legislation and is approved by Assumption Life;
f) and dispensed by an Assumption Life Approved Provider.

Assumption Life agrees to make payment for eligible Drug Benefits in the quantity prescribed and deemed reasonable by Assumption Life **(up to a maximum of a 90 day supply)**

Assumption Life reserves the right on an ongoing basis to add, delete or amend the list of eligible Drug Benefits, at its discretion and without notice.

Certain drugs may require prior authorization to be eligible for payment, as specified by Assumption Life.

When an eligible Interchangeable Drug has been prescribed, Assumption Life will make payment based on the criteria defined in Assumption Life's Pharmacy agreement(s).

Drug Benefit claims received for reimbursement directly from a Participant will be reimbursed to a maximum of the amount that would have been reimbursed directly to the Direct Payment Provider, as defined in Assumption Life's Pharmacy agreement(s).

Assumption Life will reimburse only for the lowest priced interchangeable drug when prescribed by a Physician.

Extended Health

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

Deductible	$0 Individual $0 Family
Reimbursement	90%

Paramedical Services: these expenses are reimbursed as per the reasonable, usual and customary fees. The expenses for paramedical x-rays, if applicable, are included in the paramedical services maximum amount.

Practitioners	Co-ins.	Per visit	Maximum	Frequency
Acupuncturist	90%	$0	$500	12 consecutive months
Chiropractor	90%	$0	$500	12 consecutive months
Massage Therapist, with doctor's prescription	90%	$0	$500	12 consecutive months
Naturopath	90%	$0	$500	12 consecutive months
Osteopath	90%	$0	$500	12 consecutive months
Physiotherapist	90%	$0	$500	12 consecutive months
Podiatrist	90%	$0	$500	12 consecutive months
Psychologist	90%	$0	$500	12 consecutive months
Speech-language pathologist	90%	$0	$500	12 consecutive months
Global Maximum	100%	$0	$1,000	12 consecutive months

Other Expenses: these expenses are reimbursed as per the reasonable, usual and customary fees.

Services	Maximum	Frequency
Nursing Services	$5,000	Calendar Year
Hearing Aid	$2,000	36 consecutive months
Orthopedic Footwear and Insoles	$225	Calendar Year
Fertility Drugs	$3,000	Per lifetime
Insulin pumps with a medical practitioner prescription	$6,000	Per 5 years
Smoking cessation products (including OTC)	$600	Per lifetime
Intra Uterine Device	$350	12 consecutive months

Vision Care

- Expenses for one **eye examination** by an authorized optometrist or ophthalmologist per period of 24 consecutive months for adults and 12 consecutive months for children less than 21 years of age. **(up to usual, customary and reasonable expenses)**

- Expenses for **eyeglasses (including frames), contact or laser surgery** prescribed by a physician or an optometrist, up to $200 per person per period of 24 consecutive months for adults and 12 consecutive months for children less than 21 years of age.

Travel Insurance

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

Convalescent Hospital

The charges made for a convalescent hospital room board and other necessary services, in excess of the charge for ward accommodation, up to a maximum of $20 per day will be considered eligible expenses. However, the person insured must be admitted to the convalescent hospital within 14 days following a period of at least five consecutive days as a bed patient in a hospital. Expenses will be deemed as eligible only where convalescent hospitalization is prescribed by the attending physician. Benefits shall be paid for a maximum period of 120 days during any one period of disability. All confinements in a convalescent hospital will be considered as a one period of disability, unless separated by at least 90 days. In order to qualify under these covered expenses, the convalescent hospital must be approved **by the appropriate Provincial Housing Authority**. Charges for custodial care in a convalescent hospital, nursing home or similar institution will not be considered eligible expenses.

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

a. the date on which the participant reaches 75 years of age; **65 for travel insurance**
b. the date of the participant's retirement;
c. the date on which the insurance terminates.
d. the date on which the participant is no longer employed by the employer.

Furthermore, benefits for insured dependents shall end on the date the insured dependent reaches 75 years of age if this date precedes those described above with the exception of Travel Insurance, **which terminates at age 65**.

DENTAL CARE INSURANCE

Deductible:	Individual	$0
	Family	$0

		Coinsurance
Part I	Basic (Diagnostic, prevention, oral surgery, minor restoration, repair of prosthesis)	80%
	Endodontic	80%
	Periodontic	80%
Part II	Major Restoration	50%
Part III	Prosthodontics	N/A
Part IV	Orthodontics (child less than 21 years)	N/A

Maximum expenses per insured:
Part I & II per calendar year $1,500

*The recall exam is limited to one every 6 months

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

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

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

Furthermore, benefits for insured dependents shall end on the date the insured dependent reaches 75 years of age if this date precedes those described.

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

GENERAL PROVISION

Eligibility of Employee

An employee must have completed 1200 hours of service in 12 consecutive months. They must then work at least 500 hours per calendar year to maintain their coverage. The application must be returned within 45 days of the date of eligibility.

An employee who is not actively working on a full-time basis on the day when he or she would otherwise be eligible for insurance, becomes eligible at the date of his or her return to active work on a full-time basis.

Note: Hours can be combined with one or more participating nursing homes.

Important Note:

Participation to the group life, single health and single dental is mandatory for all employees having met the eligibility requirements as detailed in the contract/collective agreement. The benefit administrator and employee will have a due diligence responsibility to provide the insurer with a signed enrolment form.

Eligibility of Dependents

Coverage for eligible dependents will commence on the same date as the employee or at the date they subsequently become dependents. Application for dependent coverage must be made within 45 days of their becoming eligible. If not, proof of insurability will be required before coverage is approved.

Dependents

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

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

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

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

Note : For Quebec residents

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

Children: An unmarried child of the employee (including natural children, stepchildren and adopted children), of his or her spouse, or of both of them, who depends on the employee for his or her support and who:

a) is younger than 21 years of age;

b) is 21 or older but younger than 25 if he or she is a regular full-time day student in a recognized academic institution; or

c) 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.

Effective Date of Insurance

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

- the date of eligibility, if the insurance application is received by the insurer within 45 days following this date; or,
- the date the insurer receives and accepts the proof of insurability submitted as a result of the insurance application being submitted later than 45 days after the date of eligibility.

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

Termination of Insurance

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

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

Submitting a Claim

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

LIFE INSURANCE

Scope

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

Waiver or Premium

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

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

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

Conversion Privilege

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

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

OPTIONAL LIFE INSURANCE

Eligibility

New employees have access to $25,000 of optional life coverage without having to complete medical evidence provided they apply for the optional life coverage within 45 days following their effective date of eligibility.

To be eligible for optional life insurance coverage over the amount of $25,000, the participant must complete a statement of health and provide any proof of insurability that the insurer deems necessary.

Effective Date of Insurance

This coverage being requested over the amount of $25,000 cannot take effect until the insurer receives all proof of insurability deemed necessary from the participant. When the insurer accepts the participant's application for additional optional life insurance after receiving proof of insurability, the effective date of this coverage is the date that the last item of proof of insurability was received by the insurer.

Optional Life Insurance is null and void if the participant, whether sound of mind or not, commits suicide or dies as a result of an attempted suicide during the first 2 years following the effective date of insurance. The obligation of the insurer then is limited to reimbursing the paid premiums, without interest.

Waiver or Premium

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

HEALTH CARE INSURANCE

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

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

- Expenses incurred for the following services provided upon medical recommendation:
    - the professional services of a **registered nurse** outside a hospital, provided the nurse does not normally reside under the participant's roof or is a member of the family;
    - **laboratory tests** for diagnostic purposes;
    - **blood or plasma transfusions**, the cost of **oxygen** as well as the rental of equipments required for its administration;
    - **X-ray** examinations, except for dental work, **up to $35 per insured person; per period of 12 consecutive months**.

- Expenses incurred under medical prescription:
    - when required, expenses for **ambulance transportation** to or from the nearest hospital providing adequate care, as well as air transportation if the insured person cannot be transported otherwise; **maximum eligible expenses are $5,000 per period of 12 consecutive months per eligible person;**
    - The rental or, at the insurer's discretion, purchase of a non-motorized wheelchair (including repairs), a ventilator, a hospital bed, or any other equipment normally considered to be used in a hospital for the purpose of temporary treatment. Once the original equipment purchase is approved, the rental or approved purchase of another piece of similar equipment will be limited to once every five (5) consecutive calendar years. Usual & Customary amounts apply**;**
    - the rental or purchase, at the discretion of the insurer, of **orthopaedic devised or therapeutic equipments**;
    - the cost of custom corrective devices added on to ordinary shoes or the purchase of an **orthosis or arch support**;
    - the purchase of custom orthopaedic shoes especially designed for the insured person in a specialized laboratory recognized by the Medical Society, **up to $225 per calendar year;**
    - the initial purchase of **artificial eye or limbs**;
    - the purchase of **external breast prosthesis** needed following a mastectomy, **up to $300 per 24 consecutive months**;
    - cost of necessary supplies related to **colostomy, ileostomy or urostomy**;
    - the purchase of **plaster casts, orthopaedic corsets, trusses, hernial supports, crutches or walkers**;
    - the purchase of **reagent test-sticks, syringes and needles**;
    - the purchase of a **dextrometer or glucometer, up to $200 per individual**
    - **per three years**; made-to-measure **burn pressure garments** when prescribed by a physician, **up to a maximum eligible expense of $5,000 per period of 12 consecutive months per eligible person.**

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

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

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

- The purchase of **hearing aids**, prescribed by an audiologist, **up to $2,000 per eligible person, per period of 36 months (does not include repairs)**.

- Expenses for **paramedical services, up to the amount and number of visits indicated in the Schedule of Benefits per insured person and per specialist.**

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

- **Intra-uterine devices** prescribed by a physician and obtained from a pharmacist or physician. (In Quebec the intra-uterine devices are reimbursed under the drug plan), **reimbursement for intra-uterine devices will be limited to $350 per insured person per period of 12 consecutive months.**

- Reimbursement for the purchase of a **hair prosthesis** when required for pathological condition as well as following chemotherapy treatments, **lifetime maximum of $200**.

- Reimbursement for the purchase of **surgical brassieres** following mastectomy, **annual maximum of $100**.

- Reimbursement for the purchase of **surgical stockings (varicose vein), maximum of two pairs per calendar year**.

Vision Care

The insurer pays the following expenses:

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

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

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

Limitations and Exclusions

No benefit is payable for the following expenses:

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

TRAVEL INSURANCE

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

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

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

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

Emergency and Payment Assistance

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

Medical Assistance

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

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

Non-Medical Assistance

The patient may call to obtain:

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

Coordination of Benefits

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

Limitations

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

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

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

DENTAL CARE

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

I Diagnostic

Includes examinations, diagnosis, consultations and necessary X-rays. Panoramic X-rays are provided once in a 24 consecutive month period and supplementary bite-wing X-rays are provided not more than once every six months.

Prevention

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

Oral Surgery

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

Minor Restoration

Includes amalgam (silver fillings), siliciate cement and plastic fillings.

Denture Repairs

Includes relining, rebasing, repair of broken dentures.

Endodontics

Includes pulp therapy and root canal fillings.

Periodontics

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

II Major Restoration

Includes crowns (excluding on-lays, veneers and ¾ crowns).

Coordination of Benefits

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

Limitations and Exclusions

No benefit is payable for the following expenses:

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