myHSA Catastrophic Medical Insurance

Master Policy # MYH1001

WESTERN LIFE ASSURANCE COMPANY

Administrative Office: 717 Portage Avenue, 4th Floor, Winnipeg MB R3G 0M8
Mailing Address: P.O. Box 3300, Winnipeg MB R3C 5S2
Toll Free: 888-647-5433 Ph: 204-784-6900 Fax: 877-783-6913

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INSURING AGREEMENT

Western Life Assurance Company hereby contracts with

Name and Address of Policyholder:

Participating Member Clients of the Administrator
120 6815 8 Street NE
Calgary, AB T2E 7H7

"Member Client" *means* clients who are participating in the benefit programs administered by the policy Administrator.

Master Policy Effective Date: November 1, 2012 at 12:01 A.M. standard time at the head office address of the Policyholder as stated above.

It continues in force for the period for which premium has been paid.

Renewal Date: November 1, 2013 and each November 1 thereafter, subject to the terms of this policy.

Premiums Due: Payment is due on the first of each Month and a period of sixty (60) days is allowed for the payment of every premium starting on the Premium Due date.

Western Life Assurance Company (hereinafter called the "Insurer") agrees with the Policyholder named above (hereinafter called the "Policyholder") to insure eligible persons specified herein (hereinafter individually called the "Insured Employee") and their eligible spouses and dependent children, if any, (hereinafter individually called the "Insured Spouse" and "Insured Dependent Child", respectively) and promises to pay for the benefits specified in this policy; to the extent herein limited and provided.

This agreement is made in consideration of the Policyholder's payment of the required premium.

Signed by Western Life Assurance Company at its Administrative Office in Winnipeg, Manitoba, Canada on the Master Policy Effective Date.

Vice President, Finance

President and CEO

SCHEDULE

Waiting Period for Employees: the waiting period for Employee coverage will be the period stated for their health insurance coverage under the benefit plan they are insured under to which this Policy is attached.

Coverage A	Benefit Maximum
Medical Expenses Lifetime	$ 1,000,000
Medical Expense item d), Nursing	$ 5,000
Medical Expense item e), Paramedical	$ 300
Medical Expense item i), Physiotherapy	$ 1,000
Medical Expense item j) iii) Appliances	$ 2,000
Medical Expense item j) v) Durable equipment	$ 2,000
Medical Expense item l) Return of vehicle	$ 2,000
Medical Expense item m) Meals and accommodation	$ 1,500
Medical Expense item o) Return of remains	$ 5,000
Emergency Dental	$ 2,000
Hotel Convalescence	$ 1,000

Coverage B	Benefit Maximum
Lifetime Maximums	
Benefits Lifetime, total of all expenses	$ 250,000
Benefits, total of all expenses per calendar year	$ 125,000
Benefits Lifetime, per listed expense item	$ 50,000
Yearly Maximums	
Expense item 1, Semi private room costs	$ 25,000
Expense item 2, Nursing	$ 25,000
Expense item 3, Drugs	$ 25,000
Expense item 4, Ambulance	$ 25,000
Expense item 5, Paramedical	$ 25,000
Expense item 6, Durable Equipment	$ 25,000
Expense item 7, Dental Injury	$ 25,000

Coverage B Deductible: $2,500 per person per calendar year

GENERAL POLICY DEFINITIONS

The male pronoun will be construed as the feminine when the person is a female.

"Accident" *means* a single sudden and unexpected event, which:

a) occurs at an identifiable time and place;

b) causes unexpected bodily Injury at the time it occurs; and

c) arises from an external source to the Insured Person

"Actively at Work" *means* the Employee capable of working and present at the place of work to carry out normal duties in accordance with the Employee's regular work schedule, on vacation or on a leave approved by the Employer.

"Administrator" *means* myHSA Ltd.

"Age" *means* the attained age of the Insured Person (last birthday).

"Airfare" *means* the regular fare charged for an economy class seat on a regular flight by a domestic or international scheduled air carrier, which holds an operating certificate issued by Transport Canada or by a similar governmental authority having jurisdiction over such air carrier in the country of its certification.

"Dependent Child(ren)" *means* all unmarried children of the Insured Employee, of the Spouse or of both, including the legally adopted children or those for whom the Insured Employee or the Spouse exercises or would exercise, in the case of a minor, parental authority and whom the Insured Employee or the Spouse supports and who is:

a) under age twenty-one (21); or

b) age twenty-one (21) and over but under age twenty-five (25), being a full-time student in an accredited educational institution, subject to proof of registration to the satisfaction of the Insurer; or

c) regardless of age, suffering from a severe, incurable and chronic physical or mental disability while meeting the requirements indicated above of a dependent child, rendering such child unable to pursue a substantially gainful occupation, subject to adequate medical evidence.

The Dependent Child will be covered from birth provided such child is born alive.

A Dependent Child will only be considered an Insured Dependent Child once under this policy.

"Dependents" *means* collectively, an Insured Spouse and/or an Insured Dependent Child, if applicable, eligible for insurance under a particular provision of this contract.

"Disease" *means* any unhealthy condition of the body or any part thereof occurring while this policy is in force with respect to the Insured Person whose disease is the basis of claim and for which expenses are incurred as described in the Description of Coverage section(s) of this policy.

"Emergency" *means* sudden, unexpected and not preplanned.

"Employee" *means* a person who is under age seventy (70) and who is

a) employed on a full-time, part-time or permanent basis by the Employer; or

b) a sole proprietor, partner or shareholder of the Employer; and

c) a Canadian citizen or landed immigrant; and

d) residing in Canada.

Partners, proprietors, corporation officers or directors, or Dependents will be considered as Employees only if they are Actively at Work.

A person insured as an Employee will not be eligible to be insured again as a Spouse or Dependent Child.

"Employer" *means* the Policyholder or any Employer whose Employees or a category of Employees are represented by the Policyholder of this policy.

"Hospital" *means* an institution licensed as a hospital, which is open at all times for the care and treatment of sick and injured persons, has a staff of one (1) or more Physician(s) available at all times and which continuously provides twenty-four (24) hour nursing service by Nurses. It provides organized facilities for diagnostics and surgery, is an active treatment hospital and not primarily a clinic, rest home, nursing home, convalescent hospital or similar establishment. For the purposes of this definition, hospital will include a facility or part of a facility used for rehabilitative care. For the purposes of this definition, Physicians and Nurses will not exclude an Immediate Family Member.

"Illness" *means* a Disease, mental infirmity or Sickness. Any surgery needed to donate a body part to another person, which causes Total Disability, will be considered an illness. "Total disability" as used herein means the Employee is unable, because of Injury or Sickness to engage in *any* occupation for wage or profit.

"Immediate Family Member" *means* a person at least eighteen (18) years of age, who is the son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, (all of the above include natural, adopted or step relationships), Spouse, grandson, granddaughter, grandfather or grandmother of the Employee.

"Injury" means bodily injury caused by an Accident occurring while this policy is in force as to the Insured Person whose injury is the basis of claim and resulting directly and independently of all other causes in loss covered by this policy, twenty-four (24) hours a day, anywhere in the world but in no event shall Injury mean Sickness or Disease howsoever caused unless caused by an Accident.

"Insured Person" *means* collectively, an Insured Employee, an Insured Spouse or an Insured Dependent Child, if applicable, eligible for insurance under a particular provision of this policy.

"Medically Necessary" *in reference to a given service or supply, means* such service or supply:

a) is appropriate and consistent with the diagnosis according to accepted community standard of medical treatment;

b) is not experimental or investigative in nature; and

c) cannot be omitted without adversely affecting the condition or quality of medical care.

"Month" *means* a period starting at 12:01 A.M. on the first (1st) day in a given calendar month, and ending at 12:01 A.M. on the first (1st) day in the next calendar month.

"Nurse" *means* a graduate registered nurse (R.N.) or nurse who is licensed to practise nursing services by a governmental agency having jurisdiction over such licensing. Nurse is neither the Insured Person himself nor an Immediate Family Member.

"Physician" *means* a doctor of medicine, (other than the Insured Person or an Immediate Family Member) who is licensed to practise medicine by:

a) a recognized medical licensing organization in the locale where the treatment is rendered, provided he is a member in good standing of such licensing body, or

b) a governmental agency having jurisdiction over such licensing in the locale where the treatment is rendered.

"Residence" *means* the primary dwelling in Canada of which the Employee is an occupant and the premises on which it is situated.

"Sickness" *means* an impairment of a normal physiological function and includes infections occurring while this policy is in force as the Insured Person whose sickness is the basis of claim and for which expenses are incurred as described in the Description of Coverage sections of this policy.

"Spouse" *means* an individual under the age of seventy (70) who is:

a) the person the Employee is legally married to; or

b) person of the opposite sex or the same sex who is publicly represented as the Employee's Spouse.

Only one (1) person at a time can be insured as an Employee's spouse under this contract.

Anyone who is insured as a Spouse will not also be eligible as an Employee or Dependent Child.

"Travelling Companion" *means* a person who is sharing the same booked accommodation with the Insured Person.

"Trip" *means* travel which commences on the date of departure from the Insured Person's province of Residence and continues until the return date of the Insured Person's province of Residence, subject to a maximum duration of sixty (60) consecutive days.

GENERAL POLICY PROVISIONS

SECTION 1 - ELIGIBILITY FOR INSURANCE

Employees of the Employer shall be eligible for insurance from the date as outlined in the Waiting Period mentioned in the Schedule, provided they are Actively at Work at such date.

The Employee's Dependents shall be eligible for insurance on the same date as the Employee himself or on a subsequent date on which they become Dependents of the Employee.

Employees not Actively at Work on the date on which they would otherwise be eligible for insurance shall become eligible for insurance on the first (1st) day of the Month following the date of their return to work in the capacity for which they are made eligible for insurance.

Insured Persons must be full-time residents of Canada and be covered under their Provincial Government Health care plans.

In the event that two (2) Insured Employees are Spouses of each other and eligible for insurance under this policy, one (1) of the two (2) may choose to be insured as an Insured Spouse of the other in which case they will not be considered to be an Insured Employee or both may choose to be covered as an Insured Employee in which case neither will be eligible as a Spouse.

Notwithstanding preceding paragraphs, Employees who are Actively at Work on the Master Policy Effective Date whose coverage under another group insurance policy terminates on such date shall be eligible for insurance on the date on which the present policy shall come into force.

SECTION 2 - EFFECTIVE DATE OF INDIVIDUAL INSURANCE

2.1 Employee's insurance

The Employee's insurance shall become effective on the date payment is made to the Administrator for the Employee's premium coincident with or next following the date he becomes eligible provided an application has been received by the Administrator before such date or within the thirty-one (31) days thereafter, otherwise, coverage becomes effective on the first (1st) day of the Month following acceptance of evidence of insurability by the Insurer.

2.2 Spouse and Dependent Children

Coverage for the Spouse and Dependent Children shall become effective on the date on which they become eligible, provided the Administrator receives an application prior to such date or within thirty-one (31) days following such date; otherwise, coverage becomes effective on the first (1st) day of the Month following the acceptance of evidence of insurability by the Insurer. However, following the Spouse's and Dependent Children's initial participation in the plan, coverage for any other Dependent Child shall automatically become effective on the date such child meets with the definition of Dependent Child.

Coverage for the Spouse and Dependent Children can, at no time, become effective before the Effective Date of coverage for the Employee.

2.3 Actively at Work

If an Employee is not Actively at Work on the date his insurance would otherwise become effective or on the effective date of an increase in benefits, the insurance or increase will become effective on the date he returns to being Actively at Work.

SECTION 3 - TERMINATION OF INDIVIDUAL INSURANCE

3.1 Employee

The insurance of an Insured Employee shall terminate on the earliest of:

a) the Employee's seventieth (70th) birthday;

b) the date the policy terminates;

c) the date the participating group/association terminates;

d) the last day of the Month in which the Insured Employee ceases to be eligible for insurance;

e) the premium due date required for an Insured Employee in accordance with the conditions of this policy if such premiums are not paid to the Insurer prior to the expiration of the Grace Period;

f) the date on which the Employee collects or allows to be collected, as a result of false claims or misrepresentations originating from the Insured Person or a third party, benefit payments which are not provided by the policy, irrespective of the compulsory character of the coverage and of any other recourse which could be exercised by the Insurer;

g) the date the Employee ceases to be a Canadian resident;

h) the date the Employee ceases to be covered by a Provincial Health insurance plan.

3.2 Dependents

The insurance of an Insured Spouse or Insured Dependent Child shall terminate on the earliest of:

a) the date the Employee's insurance ceases;

b) the date the Employee ceases to be in a class of Employees eligible for Dependents insurance;

c) the date the Dependent no longer qualifies as a Dependent.

SECTION 4 - CONTINUATION OF INDIVIDUAL COVERAGE

4.1 Continuation of Coverage

If an Employee is not Actively at Work due to temporary layoff or leave of absence, the insurance will be continued until the participating Employer stops paying to the Administrator the premium amount due, as may be required by the Policyholder for the Employee or otherwise terminates the insurance. However, the insurance will not continue for more than six (6) Months past the date the Employee is no longer Actively at Work.

4.2 Reinstatement of Individual Coverage

Wherever used throughout this policy, "Reinstatement" shall refer to this section.

If the insurance on an Employee ceased because he was no longer employed in a class of eligible Employees, he is not required to satisfy any Waiting Period if he again becomes a member of a class of eligible Employees within six (6) Months after his insurance ceased.

SECTION 5 - CLAIMS

5.1 Beneficiary

This policy contains a provision removing or restricting the right of the group person insured to designate persons to whom or for whose benefit insurance money is to be payable.

Unless otherwise indicated, all benefits, including those benefits payable for a Dependent, will be paid to the Insured Employee.

Accrued benefits, if any, unpaid at the time of the Insured Employee's death will be paid to his/her estate.

5.2 Notice of claim

The Insured Person or his/her representative or beneficiary entitled to make a claim shall give written notice of claim to the Insurer by delivery thereof, or by sending it by registered mail to the Insurers Administrative Office not later than thirty (30) days after the Accident, Injury, or Illness causing a loss and for which expenses are incurred.

5.3 Proof of Claim

The Insured Person or his/her representative or beneficiary entitled to make a claim shall provide proof of claim within one hundred (100) days from the date a claim arises on account of Travel Emergency Medical expenses furnish proof satisfactory (may require original of receipts) to the Insurer of:

a) detailed statements showing the services rendered and the fees charged for each service;

b) copies of the allowance and payment made under the Provincial Government health plan;

c) proof of the Insured Person's date of birth.

5.4 Insurer to Furnish Forms for Proof of Claim

The Insurer shall furnish forms for proof of claim within fifteen (15) days after receiving notice of claim. Where the claimant has not received the forms within that time the claimant may submit his proof of claim in the form of a written statement giving rise to the claim.

5.5 Failure to Give Notice or Proof

Failure to give notice of claim or furnish proof of claim within the time prescribed by the above condition does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one (1) year from the date of death or the date a claim arises under this policy if it is shown that it was not reasonably possible to give notice or furnish proof within the time prescribed.

5.6 Reserving Rights

As a condition precedent to recovery of insurance money under this policy the Insurer reserves the right to:

a) examine the full details regarding the claim;

b) require the Insured Person to undergo a medical examination at the Insurer's expense;

c) examine the Insured Person when and so often as is reasonably required while the claim hereunder is pending;

d) require an autopsy to be performed on the Insured Person in the event of death, unless prohibited by law or religious belief;

e) disallow the claim based on information developed from the attending Physician's report, medical examination, payroll records, or other sources of pertinent data.

5.7 Fraudulent Claims

Any claim for benefits under the policy which is based on false or incorrect information on an application, claim form or other documents required to verify benefits will result in the benefits being denied or the liability assumed by the Beneficiary if the benefit has already been provided or performed.

5.8 Limitations of Actions

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act (*Alberta and B.C.).

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in *The Insurance Act* (Manitoba).

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

Otherwise, in Quebec every action must be brought within three (3) years after the date evidence is furnished, and in all other provinces within one (1) year from the date of loss or such longer period as may be required under the law applicable in such province.

5.9 Subrogation

The Insurer is subrogated in all the rights of Insured Persons against the third party liable for the damage that has given rise to an entitlement to payment of benefits under this policy up to the limitation of amounts paid by the Insurer.

The Insurer may, in the exercise of its right of subrogation and if it deems that a third party is liable, require that the Insured Person sign, if applicable, an act of subrogation in its favor at the time of paying any benefits.

5.10 Recovering overpayments

Whenever payments have been made for allowable expenses in a total amount that exceeds the maximum payment necessary, the Insurer has the right to recover by any available legal means, such benefit overpayments from any person to who or for whom payments were made or from an Insurance company or other organization.

5.11 Coordination of coverage

If the Insured Person is covered under this policy and another insurance policy or plan, benefits will be co-ordinated with the other policy and/or plan following insurance industry standards. These standards determine where the claim should be sent first.

The guidelines are as follows:

a) if the Employee is claiming expenses for the Insured Spouse and the Spouse is covered for those expenses under another plan, the claim should be sent to the Spouse's plan first.

b) if the Employee is claiming expenses for Insured Dependent Child(ren), and both the Employee and Spouse have coverage under different plans, the Employee must claim under the plan of the parent with the earlier birthday (month and day) in the calendar year. For example, if the Employee's birthday is May 1 and the Spouse's birthday is June 5, the Employee must claim under his plan first. If both parents have the same birthday, claim under the plan of the parent whose first name begins with the earlier letter of the alphabet.

c) the maximum amount that the Employee can receive from all plans for eligible expenses is one hundred per cent (100%) of actual expenses.

d) when submitting a claim to a second payor, include payment details provided by the first payor.

SECTION 6 - PREMIUMS

6.1 Monthly premium statement

A monthly premium statement will be prepared as of the premium due date. This monthly premium statement will show the premium due and will reflect any pro rata premium charges and credits due to changes in the number of Employees and changes in insurance amounts that took place in the preceding Month.

6.2 Calculation of premiums

The monthly premium will be calculated as follows:

a) multiply the number of Employees insured on the premium due date in each rate class by the premium rate in effect on that date for that class;

b) add the results.

6.3 Changes in premium rates

Any premium rate may be changed by the Insurer from time to time with at least thirty-one (31) days advance written notice. No change in rates will be made until six (6) Months after the Master Policy Effective Date. Thereafter, an increase in rates will not be made more often than once in a six (6) Month period.

However, the Insurer may change rates immediately if, in the Insurer's opinion, the Insurer's liability is altered by any change in provincial or federal law or by a revision in the insurance under the policy. Any such change in rates will take effect on the effective date of the change in law or change in the insurance.

No pro rata increases or decreases in rates for a single Month will be applied.

6.4 Grace period

If, before a premium due date, the Policyholder has not given written notice to the Insurer that the policy is to terminate, a grace period of thirty-one (31) days will be granted for the payment of each premium after the first premium. The policy will stay in force during that time.

If any premium is not paid by the end of the grace period, the policy will automatically terminate at the end of the grace period. However, if the Policyholder has given written notice in advance of an earlier date of termination, the policy will terminate as of the earlier date.

The Policyholder will be liable to the Insurer for any unpaid premium for the time the policy was in force.

6.5 Incorrect premium payment

Premiums paid in error for a person who is not eligible to be insured, or for a person after his insurance has ceased, will be refunded without interest when requested by the Policyholder. These premiums will not be refunded, however, for more than six (6) Month period or for any period before the last anniversary date.

SECTION 7 - CONTRACT

7.1 Administration

The Insurer will deal solely with the Policyholder or Administrator who will be deemed the representative of each participating group/association. Any action taken by the Policyholder or Administrator will be binding on the participating Insured Person(s) of the group/association.

7.2 Clerical or Mechanical Errors

If a clerical or mechanical error by the Policyholder, Administrator or the Insurer results in a person being incorrectly classified under the policy, then such person will be classified according to the true facts.

7.3 Conformity to Legislation

If this policy does not conform to legislation that governs it, it is considered automatically amended to comply with the minimum requirements of that legislation.

7.4 Currency

All payments made under the policy, either to or by the Insurer will be in the lawful money of Canada.

7.5 Entire Contract

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

7.6 Insurance data

The Administrator will give the Insurer all of the data that is needed to calculate the premium and all other data that is reasonably required. Failure of the Administrator to give this data will not void or continue an Employee's insurance.

The Insurer has the right to examine the Policyholder's records relative to these benefits at any reasonable time while the policy is in effect. The Insurer also has this right until all rights and obligations under the policy are finally determined.

7.7 Insured Right of Access

As required by your provincial legislation, or if you reside in Alberta or B.C., the Insured Person and any claimant may request a copy of the Insured Person's application, any written evidence of insurability and the Group Policy (other than confidential commercial information or other information exempted from disclosure by applicable law).

7.8 Material Facts

No statement made by the Insured Person at the time of application for this policy shall be used in defense of a claim under or to avoid this contract unless it is contained in the application or any other written statement or answers furnished as evidence of insurability.

7.9 Misrepresentation and Incontestability

The policy will be void and the Insurer's liability will be limited to the return of any premiums paid if incomplete, inaccurate, untrue or wrong information was submitted to the Insurer at any time and a claim arises under the policy during the first two (2) years from the Effective Date of Individual Insurance or two (2) years from most recent date of Reinstatement.

7.10 Misstatement of Age

If the age of an Insured Person has been misstated, the corrected age and facts will be used to determine whether insurance is in force under the policy and in what amount, and an equitable adjustment of premium will be made.

7.11 Misstatement of Tobacco Use

The Insurer uses a more favorable basis to calculate premiums and monthly charges for non-tobacco users. If the Insured Person falsely answers questions related to his tobacco use in any application for this coverage (including any application to reinstate), the policy will be considered void from inception. The term "void" means that the policy is no longer a binding contract and is cancelled from inception.

7.12 Non-Participating

This policy does not share in the Insurer's surplus earnings.

7.13 Replacement

This policy is considered a replacement policy if it replaces previous group coverage providing similar insurance benefits that the Employer terminated less than thirty-one (31) days prior to the Master Policy Effective Date.

If this policy is replacing previous group coverage, the Insurer will insure an Employee and his Dependents(s) who:

a) was insured under the previous policy at the date of termination and whose coverage terminated solely because the policy terminated; and

b) is not in Actively at Work on the Master Policy Effective Date; and

c) is a member of a class of eligible Employees.

While such Employee is not Actively at Work, each Employee and Dependents(s) will be insured for the lesser of:

a) the amount of coverage that they will become eligible for under this policy, and

b) the amount of coverage that were insured for under the previous policy.

However, no benefits will be payable under this policy for which benefits are payable under the previous policy.

7.14 Termination by the Group/Association

The participating group/association may terminate this insurance by advance written notice delivered to the Insurer at least thirty-one (31) days prior to the termination date.

7.15 Termination by the Insurer

The Insurer may terminate the policy by advance written notice delivered to the Policyholder at least thirty-one (31) days prior to the termination date.

7.16 Termination by the Policyholder

The Policyholder may terminate the policy on any premium due date by giving the Insurer written notice thirty-one (31) days before that date.

7.17 Waiver

The Insurer shall be deemed not to have waived any condition of this contract, either in whole or in part, unless the waiver is clearly expressed in writing signed by the Insurer.

COVERAGE A: TRAVEL EMERGENCY MEDICAL

SECTION A1 - DESCRIPTION OF COVERAGE

In accordance with the provisions of this policy, the Insurer will pay to the beneficiary all eligible benefits up to the maximum amounts insured only if the service(s) were required as a result of Emergency Illness or Injury which occurred while the Insured Person was on a Trip and which required immediate medical services.

Coverage is limited to a maximum of sixty (60) days per Trip commencing with the date of departure from the Insured Person's province of Residence. If the Insured Person is hospitalized on the sixtieth (60^{th}) day, benefits will be extended until the date of discharge.

SECTION A2 - AMOUNT OF TRAVEL EMERGENCY MEDICAL

The total amount payable for reimbursement of all expenses, which an Insured Person has incurred as the result of Injuries caused by Accident or as the result of Illness, will not exceed the lifetime maximum as stated in the Schedule.

SECTION A3 - BENEFITS

A3.1 Medical Expenses

Charges for eligible services shown below will be reimbursed based on usual, reasonable and customary charges in the area where they were received, less the amount payable by the Insured Person's Provincial Government health plan and/or any other insurance plan providing similar coverage's.

a) Hospital services and accommodation up to and including semi-private accommodation level in a Hospital, subject to a maximum duration of twelve (12) Months.

b) Medical/surgical services rendered by a legally qualified Physician or surgeon.

c) Expenses for the services of a licensed anaesthetist when recommended by a Physician.

d) Expenses for the services of a Nurse ordered or prescribed by a Physician, provided the Nurse does not ordinarily reside in the Insured Person's Residence, subject to the maximum stated in the Schedule, per Accident or Illness.

e) Expenses for the services of any of the following practitioners, provided such practitioner is duly licensed or duly registered where required in the province of practise and does not ordinarily reside in the Insured Person's Residence and is not an Immediate Family Member, subject to the maximum stated in the Schedule, per specialty, per Accident, or Illness (such services do not require the recommendation of a Physician except as indicated below):

   i) chiropractor

   ii) osteopath

   iii) chiropodist or podiatrist

   iv) massage therapist, on the recommendation of a Physician

   v) speech therapist

   vi) psychologist

   Expenses for diagnostic x-rays and laboratory tests ordered by a chiropractor, osteopath, chiropodist or podiatrist will be allowed as expenses under the services of such practitioners, subject to a maximum of one (1) x-ray per practitioner for each Insured Person per Accident or Illness.

f) Land ambulance to the nearest qualified medical facility.

g) Air ambulance (including a medical attendant when necessary) that is Medically Necessary in order for the Insured Person to travel to the Insured Person's province of Residence and if the Insured Person cannot travel by any other means of transportation.

h) Charges for prescription drugs, sera and vaccines, obtainable only upon a written prescription by a Physician or legally qualified dentist and dispensed by a registered pharmacist or Physician, but excluding any charges made for the administration of injectable drugs, sera and vaccines, subject to a dispensing maximum of a thirty (30) day supply.

i) Expenses charged for the services of a duly licensed or duly registered physiotherapist for physiotherapy treatment ordered or prescribed by a Physician, provided such physiotherapist does not ordinarily reside in the Insured Person's Residence and is not an Immediate Family Member, subject to the maximum stated in the Schedule, per Accident or Illness.

j) Expenses incurred for the following:

   i) blood plasma, whole blood or oxygen, including the administration thereof;

   ii) x-rays and laboratory examinations which are required for diagnostic purposes;

   iii) artificial limbs, eyes or other prosthetic appliances, subject to the maximum stated in the Schedule, per calendar year;

   iv) rental or purchase of casts, cervical collars, crutches, trusses, splints and braces (except dental braces and splints);

   v) rental of a wheelchair, an iron lung and other durable medical equipment for temporary therapeutic treatment, subject to the maximum stated in the Schedule, per Accident, or Illness.

k) Mondial Assistance travel protection coverage.

l) Cost of returning the Insured Person's vehicle, either private or rental, to the Insured Person's Residence or nearest appropriate vehicle rental agency when the Insured Person is unable to due to Illness or Injury subject to the maximum stated in the Schedule. Requires original receipts for costs incurred, i.e., gasoline, accommodation, airfares.

m) Meals and accommodation subject to the maximum stated in the Schedule, (one hundred and fifty dollars ($150.00) per day for ten (10) days) will be reimbursed for the extra costs of commercial accommodation and meals incurred by the Insured Person when the Insured Person remains with a Travelling Companion or Dependent, when the Trip is delayed or interrupted due to an Illness or Injury to a Travelling Companion or Dependent. The Illness or Injury must be verified in writing by the attending Physician and the expenses for meals and accommodations must be supported with original receipts from commercial organizations.

n) Transportation for an Immediate Family Member to the bedside of the Insured Person including round trip economy Airfare by the most direct route from the Insured Person's province of Residence, and up to one hundred and fifty dollars ($150) per day for a maximum of five (5) days accommodation will be paid for that Immediate Family Member to

   i) be with the Insured Person confined in Hospital; or

   ii) to identify the deceased prior to release of the body.

   With respect to item n) i) in order to qualify for benefits the Insured Person must eventually be an in-patient for at least seven (7) days outside the Insured Person's province of Residence, plus the written verification of the attending Physician that the situation was serious enough to have required the visit.

o) Return of deceased subject to the maximum stated in the Schedule, toward the cost of preparation (including cremation) and homeward transportation of a deceased Insured Person when death is caused by Illness or Injury. The Insured Persons remains will be returned to the point of departure in the Insured Person's province of Residence. Benefits include the cost of a burial coffin.

A3.2 Emergency Dental Treatment Expense

When, by reason of Injury to whole and sound teeth (capped or crowned teeth will, for the purposes of this policy, be considered whole and sound), due to a force or blow external to the mouth, requires treatment, replacement or x-rays by a legally qualified dentist or oral surgeon who does not ordinarily reside in the Insured Person's Residence and is not an Immediate Family Member, within thirty (30) days from the date of the Injury, the Insurer will pay the reasonable and necessary expenses actually incurred by the Insured Person, subject to the maximum stated in the Schedule, as a result of any one (1) Accident.

Any payments made under this section will be in accordance with the current Fee Guide for General Practitioners published by the Dental Association in the Insured Person's province of Residence.

Alberta Only - any payments made under this section will be in accordance with the 1997 Alberta Fee Guide for General Practitioners plus an annual inflationary adjustment as determined by the Alberta Dental Association and the insurance industry and documented in the Insurance Industry Reimbursement Guide.

A3.3 Hotel Convalescence Expense

If, as the result of Injury or Illness, the attending Physician certifies in writing that the Insured Person, due to his medical condition, is prohibited from resuming any travel following discharge from the Hospital where the Insured Person was confined for a period of not less than seven (7) days, the Insurer will pay the reasonable and necessary expenses actually incurred for board and Accommodation subject to the maximum stated in the Schedule, per Accident or Illness.

"Accommodation" *as* used above *means* commercial lodging in the vicinity of the Hospital where the Insured Person is confined.

SECTION A4 - TRAVEL EMERGENCY MEDICAL LIMITATIONS

The following limitations to the coverage provided under Coverage A: Travel Emergency Medical will apply:

a) coverage for each Trip begins when an Insured Person leaves the border of his province of Residence or if travelling by Aircraft, when such Aircraft takes off in his province of Residence, provided insurance is in force with respect to such Insured Person in accordance with Section 2 - Effective Date of Individual Insurance;

b) coverage for each Trip terminates when an Insured Person crosses the border of his province of Residence when returning from a Trip or if travelling by Aircraft, when such Aircraft lands in his province of Residence or sixty (60) days following the date of departure from his province of Residence, whichever is earlier;

c) all expenses must be incurred on a non-elective Emergency basis outside the Insured Person's province of Residence and are in excess of expenses under any individual, group or government sponsored hospital or medical reimbursement plan;

d) in consultation with the attending Physician, the Insurer reserves the right to transfer an Insured Person to another Hospital or to return an Insured Person to his province of Residence for necessary treatment. In the event the Insured Person refuses to comply, the Insurer will no longer be liable for further expenses incurred, which are relating to the condition causing the treatment, after the proposed transfer date.

e) Mondial Assistance must be notified within forty-eight (48) hours of an Emergency, or when reasonably possible, following an Emergency. Claims may be reduced if contact is not made with Mondial Assistance within forty-eight (48) hours of admission to Hospital.

SECTION A5 - TRAVEL EMERGENCY MEDICAL EXCLUSIONS

Coverage A: Travel Emergency Medical does not cover loss, fatal or non-fatal, caused or contributed to by or resulting from:

a) intentionally self-inflicted Injury while sane or self-inflicted Injury while insane;

b) declared or undeclared war or any acts thereof;

c) perpetration of acts of terrorism;

d) participation in a riot, insurrection or civil commotion;

e) active full-time, part-time or temporary service in the armed forces of any county;

f) pregnancy, or childbirth, except complications thereof which will be treated as any other Sickness;

g) a Trip undertaken by the Insured Person for the purpose of obtaining medical treatment, assessment or consultation;

h) participation in any professional athletics;

i) participation in acrobatic, stunt or ultra-light flying, mountaineering, hang gliding, scuba diving, any racing or speed contests.

Coverage A: Travel Emergency Medical does not cover any of the following supplies or services or costs thereof:

a) expenses covered under any government hospital, medical, dental or health care insurance plan, whether payable or not, or expenses for which insurance is prohibited by law;

b) medical examinations for the use of a third (3rd) party;

c) cosmetic surgery and dental services other than those required as a result of an Accident;

d) oral contraceptives and patent medicines;

e) charges for experimental drugs not approved by the governing authority having jurisdiction over the matter in the country where such drugs are prescribed and dispensed;

f) charges for any experimental medical treatments;

g) services for which no charge would ordinarily be made if there was no insurance coverage;

h) expenses incurred for treatment or surgery which medically could be delayed until the Insured Person has returned to his province of Residence;

i) medical expenses for treatment or surgery which the Insured Person elects to have rendered or performed outside his province of Residence, following Emergency treatment for a diagnosis of a medical condition which (on medical evidence) would not prevent the Insured Person from returning to his province of Residence prior to such treatment or surgery.

Travel Emergency Medical Pre Existing Exclusion

Coverage A: Travel Emergency Medical does not cover loss (fatal or non-fatal) or expenses caused by or resulting from any condition for which the Insured Person received medical advice, consultation or treatment within six (6) Months prior to the commencement of a Trip, with the exception of a Chronic Condition which is under treatment and Stabilized by the regular use of prescribed medication.

This exclusion applies to Insured Persons who are insured under this policy within a Member Client comprised of less than two (2) Insured Employees.

"Chronic Condition" *means* a Disease or disorder which has existed for a minimum of six (6) Months.

"Stabilized" *means* there has not been a change in the medical condition requiring medical or psychiatric intervention for a minimum of six (6) Months.

COVERAGE B: EXCESS MEDICAL

SECTION B1 - DESCRIPTION OF COVERAGE

In accordance with the provisions of this policy, the Insurer will reimburse the reasonable and necessary charges for services or supplies received by the Insured Person within two (2) years following the date the initial deductible under this plan is satisfied for such Eligible Expenses if an Insured Person requires medical or surgical treatment and incurs Eligible Expenses as described in Section B3 - Benefits as a result of Injury or Illness.

SECTION B2 - AMOUNT OF EXCESS MEDICAL

The total amount payable for reimbursement of all expenses, which an Insured Person has incurred as the result of all Injuries caused any one (1) Accident or as the result of any one (1) Illness, will not exceed the all expense maximum per calendar year and the lifetime maximums as stated in the Schedule.

SECTION B3 - BENEFITS

The eligible expenses are:

a) Hospital charges for the difference between the public ward allowance under the Insured Person's Provincial Hospital plan and the semi-private accommodation charge (private accommodation if recommended by a Physician), subject to a maximum duration of twelve (12) Months, and subject to the maximum stated in the Schedule, per calendar year, per Accident, or Illness;

b) expenses for the services of a Nurse ordered or prescribed by a Physician, provided the Nurse does not ordinarily reside in the Insured Person's Residence, subject to the maximum stated in the Schedule, per Accident, or Illness;

c) charges for prescription drugs, sera and vaccines, obtainable only upon a written prescription by a Physician or legally qualified dentist and dispensed by a registered pharmacist or Physician, but excluding any charges made for the administration of injectable drugs, sera and vaccines, subject to a dispensing maximum of a thirty (30) day supply and subject to the maximum stated in the Schedule, per calendar year, per Accident or Illness;

d) expenses for a licensed ground ambulance service or, when recommended by a Physician, by any other conveyance licensed to carry passengers for hire, including air ambulance, to or from the nearest Hospital which is equipped to provide the required treatment subject to the maximum stated in the Schedule, per Accident or Illness;

e) expenses for the services of any of the following licensed practitioners, provided such practitioner does not ordinarily reside in the Insured Person's Residence and is not an Immediate Family Member up to fifty dollars ($50) per treatment, subject to the maximum stated in the Schedule, per calendar year (such services do not require the recommendation of a Physician except as indicated below):

    i) chiropractor

    ii) osteopath

    iii) chiropodist or podiatrist

    iv) licensed masseur, on the recommendation of a Physician

    v) speech therapist

    vi) licensed psychologist

    Expenses for diagnostic x-rays and laboratory tests ordered by a chiropractor, osteopath, chiropodist or podiatrist will be allowed as expenses under the services of such practitioners, subject to a maximum of one (1) x-ray per practitioner for each Insured Person in any one (1) calendar year.

f) expenses for rental of a wheelchair, an iron lung and other durable equipment for temporary therapeutic treatment, not to exceed the purchase price prevailing at the time rental became necessary, subject to the maximum stated in the Schedule, per Accident or Illness;

g) when Injury to whole and sound teeth (capped or crowned teeth will, for the purposes of this policy, be considered whole and sound), due to a force or blow external to the mouth, requires treatment, replacement or x-rays by a legally qualified dentist or oral surgeon, the Insurer will pay the reasonable and necessary expenses actually incurred by the Insured Person, subject to the maximum stated in the Schedule, as a result of any one (1) Accident;

Any payments made under this section will be in accordance with the current Fee Guide for General Practitioners published by the Dental Association in the Insured Person's province of Residence.

With respect to the province of Alberta any payments made under this section will be in accordance with the 1997 Alberta Fee Guide for General Practitioners plus an annual inflationary adjustment as determined by the Alberta Dental Association and the insurance industry and documented in the Insurance Industry Reimbursement Guide.

SECTION B4 - DEDUCTIBLE

There is a deductible per calendar year in the amount stated in the Schedule. The deductible amount applies to all eligible expenses stated in Section B3 - Benefits as a result of Injury or Illness.

Reimbursement of insured expenses commences following satisfaction of the deductible amount, if any.

SECTION B5 - RECURRENT INJURY, SICKNESS OR DISEASE

If an Injury or Illness causes the Insured Person to incur eligible expenses following which a continuous period of six (6) or more Months elapses during which the same Injury or Illness does not cause the Insured Person to incur any eligible expenses and does not require any treatment of the Insured Person by a Physician, the Insured Person will be deemed to have recovered from the Injury or Illness at the end of the period of six (6) or more Months.

Thereafter, a subsequent recurrence of the Injury or Illness, which causes the Insured Person to incur eligible expenses will be deemed to be a different Injury or Illness to which the full maximum limit of indemnity will be applicable without any reduction or variation by reason of eligible expenses incurred as a result of the Injury or Illness from which the Insured Person was deemed to have recovered.

SECTION B6 - EXCLUSIONS, LIMITATIONS, AND SPECIAL PROVISIONS

Coverage B: Excess Medical does not cover any charges for Injury or Illness caused directly or indirectly, in whole or in part by any of the following:

a) intentionally self-inflicted Injury while sane or insane;

b) declared or undeclared war or any acts thereof;

c) perpetration of acts of terrorism;

d) participation in a riot, insurrection or civil commotion;

e) active full-time, part-time or temporary service in the armed forces of any county;

f) any treatment, surgery, care service, examination or device which:

i) is not Medically Necessary;

ii) is provided or required for cosmetic purposes;

iii) is conducted as an experiment;

iv) is provided or required for non-curative reasons; or

v) exceeds what is ordinarily provided or required by current therapeutic practice;

g) any treatment related to or provided for drug addiction;

h) while the Insured Person is committing or attempting to commit an assault, battery or criminal offence, whether or not the Insured Person has been charged with a criminal offence;

i) operating a motorized vehicle where the Insured Person:

   i) was found to have a blood alcohol level in excess of eighty (80) milligrams of alcohol per one hundred (100) milliliters of blood; or

   ii) has been convicted of an alcohol-related offence such as driving while impaired; or

   iii) has refused to take a breathalyser test.

j) if the Insured Person was negligent or non-compliant in seeking and/or following reasonable medical treatment, consultation, care or services including diagnostic measure as prescribed by their attending Physician.

Coverage B: Excess Medical does not cover any of the following supplies or services or costs thereof:

a) expenses incurred outside of Canada;

b) therapeutic or elective abortion;

c) services or supplies associated with:

   i) erectile dysfunction;

   ii) the diagnosis or treatment of infertility;

   iii) contraception,

d) homeopathic preparations, unless federal or provincial legislation requires a prescription for their sale;

e) drugs which do not legally require a prescription and pharmaceutical supplies which are either experimental or not approved by the Canadian government or Provincial government regulatory body in the Insured Person's province of Residence.

Exclusion for pre-existing condition(s)

Benefits are not payable as a result of any pre-existing condition unless Excess Medical costs commence after the Insured Person has been continuously insured for twenty-four (24) Months after the Effective Date of their insurance or the date of their last Reinstatement.

Pre-existing conditions means any Injury, Illness, nervous disorder or any symptom or other condition for which medical advice, consultation, investigation, diagnosis or treatment, including medication, was required or recommended by a Physician, or for which a reasonable person would have sought treatment or advice, during the twenty-four (24) Month period prior to the Effective Date of insurance.

This exclusion applies to Insured Persons who are insured under this policy within a Member Client comprised of less than two (2) Insured Employees.