



SoloPLUS

Benefits Booklet

Program Administrator:
GroupHEALTH Global
Benefits Systems Inc.



Schedule of Benefits for SoloPLUS Better

Unless otherwise specified, all benefit limits specified in this policy are per Insured per calendar year. This policy contains clauses that may limit coverage. It is important to read this policy carefully in order to understand what is covered and what is not covered. Please keep it in a safe place with your other important documents.

10-DAY RIGHT TO EXAMINE POLICY

The Policyholder has the right to examine this policy after taking delivery of it. If he/she is not satisfied with the terms and conditions of coverage, he/she can return the policy and pay-direct card within ten (10) days after receipt to the Plan Administrator. The policy will be voided and any premium paid will be refunded, provided a claim for benefits has not been made.

Policyholder Name:

Policy Number:

Effective Date:

(at 12:01am local time at the address of the Policyholder)

Coverage:

Premium Due Date:

The first monthly premium is due and payable on the Effective Date. Subsequent monthly premiums are payable in advance on the first day of each month.

Application Age Limit of Policyholder:

Age 65

Application Age Limit of Spouse:

Age 65

Age Limit for Dependent Children:

All unmarried dependent children under 22 years of age, (25 years of age if attending school on a full-time basis) or to age 69 if mentally or physically disabled

Termination Age of Policyholder or Covered Spouse:

Age 90

Plan Administrator:

GroupHEALTH Global Partners Inc.

Third Party Administrator:

Alternative Benefits Solution Inc.

Assistance Company/Out-of-Country Travel Medical Coverage:

Not Included

Overall Aggregate Lifetime Maximum for all benefits:

\$250,000 per Insured

Supplementary Health Benefits Summary

| | |
|--|---|
| % Payment of Eligible Expenses: | |
| Paramedical Practitioners | 100% to maximum of limits stated below |
| Vision Care | 100% to maximum of limits stated below |
| All Other Eligible Expenses | 100% to maximum of limits stated below |
| Vision Care: | |
| Eye Examinations | Up to \$75 every 24 months, subject to a 6 month waiting period |
| Eyeglasses or Contact Lenses | Up to \$150 every 24 months, subject to a 6 month waiting period |
| Hospital Accommodation: | Up to \$150 per day to a maximum of \$4,500 for semi-private hospital rooms |
| Hearing Aids: | Up to \$400 every 4 years |
| Private Duty Nursing: | Up to \$3,000 for services of a registered graduate nurse combined with Durable Medical Equipment & Supplies and Prosthetics |
| Paramedical Practitioners: | Up to \$25 per visit to a maximum of \$500 combined for all of the following practitioners: Acupuncturist; Chiropractor; Chiropodist; Naturopath; Osteopath; Podiatrist; Registered Massage Therapist; Physiotherapist; Psychologist; Speech Therapist (All services must be prescribed by a Physician). |
| Chiropractic X-rays: | Up to \$35 per year |
| Durable Medical Equipment & Supplies: | Up to a maximum of \$3,000 combined with Private Duty Nursing and Prosthetics |
| Blood Pressure Monitors | Up to \$250 every 5 calendar years, subject to the overall annual maximum for Durable Medical Equipment & Supplies specified above. |
| Medical Braces | Up to \$250 every 2 calendar years, subject to the overall annual maximum for Durable Medical Equipment & Supplies specified above. |



GENERAL INSURANCE COMPANY



INDIVIDUAL HEALTH INSURANCE POLICY

| | |
|--|---|
| Insulin pumps | Up to \$2,500 every 5 calendar years, subject to the overall annual maximum for Durable Medical Equipment & Supplies specified above. |
| Respiratory & Sleep Apnea Equipment | Up to \$1,250 every 5 calendar years, subject to the overall annual maximum for Durable Medical Equipment & Supplies specified above. |
| Prosthetics: | Up to a maximum of \$3,000 combined with Private Duty Nursing and Durable Medical Equipment & Supplies |
| Wigs required as a result of chemotherapy: | Lifetime maximum of \$200, subject to the overall annual maximum for Prosthetics specified above. |
| Orthopaedic Footwear or Orthotics: | Up to \$300, subject to the overall annual maximum for Prosthetics specified above. |
| External Prosthetics & Artificial Limbs | Lifetime maximum of \$3,000, subject to the overall annual maximum for Prosthetics specified above. |
| Ambulance: | Ground transportation Up to \$4,000 for air transportation (for services not covered by GHIP) |
| Accidental Dental: | Up to \$2,500 |



GENERAL INSURANCE COMPANY



INDIVIDUAL HEALTH INSURANCE POLICY

Prescription Drug Benefits Summary

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|--|--|
| Overall Aggregate Annual Maximum per Insured: | Up to \$3,500 |
| Additional Conditions: | Generic drugs only. Dispensing fee cap of \$7.50 per prescription. |
| % Payment of Eligible Expenses: | 100% to the maximum limit stated above |
| Erectile Dysfunction Drugs: | Not Included |
| Smoking Cessation Products: | Not Included |
| Anti-Obesity Drugs: | Not Included |
| Fertility Drugs: | Not Included |
| Extemporaneous Compound Preparations: | Not Included |

Dental Care Benefits Summary

Overall Aggregate Annual Maximum per Insured:

Up to \$750 for the following services combined, when included as coverage under the policy, subject to a 3 month waiting period:

| | |
|------------------------------|--------------|
| Preventative Services | Included |
| Basic Services | Included |
| Major Services | Not Included |
| Orthodontic Services | Not Included |

% Payment of Eligible Expenses:

| | |
|------------------------------|--|
| Preventative Services | 80% to the combined maximum stated above |
| Basic Services | 80% to the combined maximum stated above |
| Major Services | Not Included |
| Orthodontic Services | Not Included |

Frequency of Treatment:

| | |
|-------------------------------------|----------------------|
| Oral examination | Once every 36 months |
| Recall oral examination | Once every 9 months |
| Prophylaxis | Once every 9 months |
| Preventative recall packages | Once every 9 months |
| Replacement of prostheses | Not Included |
| Scaling and root planing | 6 units |

Treatment Plan:

A Treatment Plan must be submitted to the Third Party Administrator when total costs of a treatment is expected to exceed \$500.

Fee Guide:

Current fee guide for General Practitioners in the province/territory where the expenses were incurred

1. DEFINITIONS

- 1.1. Acts of Terrorism** means ideologically motivated unlawful act or acts, including but not limited to the use of violence or force or threat of violence or force, committed by on or behalf of any group(s), organization(s) or government(s) for the purpose of influencing any government and/or instilling fear in the public or a section of the public.
- 1.2. Class** means a grouping of insured persons by occupation, plan type and/or province or territory.
- 1.3. Couple Coverage** means coverage for the Policyholder and one eligible Dependent.
- 1.4. Dependent** means a Policyholder's Spouse and/or Dependent Children, whether taken individually or collectively.
- 1.5. Dependent Child(ren)** means a Policyholder's or a Policyholder's Spouse's unmarried, natural, step, adopted or foster child(ren) who depend on the Policyholder for financial support and who meet the Age Limit for Dependent Children requirements specified in the Schedule of Benefits.

A foster child is a child for whom the Policyholder has legal guardianship, appropriate documentation must be provided to verify the court appointed legal guardian status.

A dependent child who is physically or mentally disabled and totally dependent on the Policyholder for support will continue to be eligible provided he/she:

- (i) was covered as a Dependent under the Policy before attaining such age limit;
- (ii) is eligible for disability deduction on the Policyholder's personal tax return; and
- (iii) is incapable of self-sustaining employment.

- 1.6. Dentist** means a person, not related by blood or marriage to the Insured or ordinary resident with the Insured or a business associate of the Insured, licensed to practice dentistry by the regulatory body in the jurisdiction in which he/she provides services.
- 1.7. Extemporaneous Compound Preparation** means a drug or combination of drugs prepared or compounded in a pharmacy according to a prescription.
- 1.8. Family Coverage** means coverage for the Policyholder, the Policyholder's eligible Dependents.
- 1.9. Government Health Insurance Plan** means the health care coverage provided by Canadian federal, provincial or territorial governments to their residents.
- 1.10. Hospital** means a facility that is licensed as a hospital, where inpatients receive medical care, that has a Physician on duty at all times, continuously provides twenty-four (24) hour nursing by graduate registered nurses and includes a laboratory and operating room. At no time shall Hospital mean a clinic, rehabilitation centre, continuing care or palliative care

facility, convalescent home, home for the aged, rest home, nursing home, psychiatric treatment centre, narcotic or alcohol treatment centres or health spas.

- 1.11. **Insurer** means Echelon General Insurance Company.
- 1.12. **Insured** means the Policyholder or the Policyholder's covered Dependents if Couple or Family Coverage has been applied for and approved.
- 1.13. **Medically Necessary** means, in relation to any care, service, supply or other matter, that is ordered by a Physician, Dentist or Paramedical Practitioner and that the Insurer determines is:
 - 1. Appropriate and consistent with the symptoms and findings or diagnosis and treatment of the Insured's sickness or injury;
 - 2. Provided in accordance with generally accepted medical practice on a national basis; and
 - 3. The most appropriate supply or level of service that can be provided on a cost effective basis.
- 1.14. **Nuclear Occurrence** means any occurrence causing bodily injury, illness, disease or death, arising out of or resulting from the radioactive, toxic, explosive, or other hazardous properties of source, special nuclear, or by-product material.
- 1.15. **Pharmacist** means a person, not related by blood or marriage to the Insured or ordinary resident with the Insured or a business associate of the Insured, legally authorized to dispense prescription drugs by the regulatory body in the jurisdiction in which he/she provides services.
- 1.16. **Physician** means a person, not related by blood or marriage to the Insured or ordinary resident with the Insured or a business associate of the Insured, licensed to practice medicine by the regulatory body in the jurisdiction in which he/she provides services.
- 1.17. **Plan Administrator** means the administrator named in the Schedule of Benefits who has been retained by the Insurer to administer the policy.
- 1.18. **Policyholder** means the Insured to whom this policy has been issued and who is responsible for the premium payment.
- 1.19. **Reasonable and Customary Charges** means:
 - 1. Actual charges made to the Insured for services or supplies, but not more than the fees and prices generally charged in the area concerned as determined by the Insurer, for cases of severity and nature comparable to the severity and nature of the case being treated; or
 - 2. The lowest charge indicates in the most current Provincial Dental Association Schedule of Fees, for the same services and supplies.

1.20. Spouse means a person who is either:

- (i) an Policyholder's legal spouse; or
- (ii) a person whom the Policyholder publicly acknowledge as his/her spouse and with whom he/she has been living in a permanent manner for the period of time recognized by the law in the jurisdiction in which the Policyholder resides as the length of time necessary for the recognition of a common-in-law relationship.

However, when the person is the biological or adoptive father or mother of at least one of the Policyholder's children, the spouse will be recognized as of the date of birth or adoption, if it precedes the end of the legally recognized period of cohabitation.

The person the Policyholder has designated in writing to the Insurer as his/her Spouse is recognized as his/her Dependent, until such time as the Policyholder advises otherwise.

Any dissolution of a marriage through divorce or annulment or, in the case of common-in-law marriage, actual separation for over three (3) months, results in the loss of status as Spouse, unless otherwise required by law.

1.21. Third Party Administrator means the third party administrator named in the Schedule of Benefits who has been retained by the Insurer to administer claims for any Supplementary Health Benefits, Prescription Drug Benefits and Dental Care Benefits under this policy, if such benefits are part of this policy.

2. GENERAL PROVISIONS

2.1. Agreement

The Insurer agrees to pay the benefits provided by this policy to the persons entitled to receive them, provided the Policyholder makes the required premium payments when due.

2.2. Policyholder Eligibility

To apply for benefits under this policy, an individual must meet the following eligibility requirements:

- (i) be a permanent resident of Canada;
- (ii) be covered under the Government Health Insurance Plan in his/her province or territory of residence;
- (iii) be younger than the Application Age Limit specified in the Schedule of Benefits on the date of application; and
- (iv) be actively working at least 20 hours per week on the day coverage commences.

The individual may apply for coverage by submitting an application and providing evidence of insurability along with the appropriate premium for such coverage.

2.3. Dependents Eligibility

The Policyholder may apply for coverage for eligible Dependents by submitting an application and providing evidence of insurability along with the appropriate premium for such coverage. A Spouse must be less than Application Age Limited specified in the Schedule of Benefits on the date of application. **It is not necessary to supply evidence of insurability for a newborn child if the application is submitted within thirty (30) days after the date of birth.** If a Dependent is confined in a Hospital on the date his/her insurance would otherwise become effective, no insurance on that Dependent shall become effective until he/she ceases to be so confined.

2.4. Effective Date of Coverage

The Policyholder's coverage and his/her Dependents' coverage, if any, becomes effective on the first day of the month coinciding with or next following the date on which the Insurer accepts the required evidence of insurability and approves coverage under the policy. Such evidence must be provided at no expense to the Insurer.

If a Policyholder's Dependents are already insured, each new Dependent that the Insured acquires will automatically be covered by the policy on the date that the Dependent becomes eligible.

2.5. Termination Date of Coverage

The Policyholder's benefits terminate at the earliest of the following dates:

- (i) on the date the Policyholder ceases to be a permanent resident of Canada or be covered under the Government Health Insurance Plan in his/her province or territory of residence;
- (ii) on the date of the Policyholder's death;

- (iii) on the date the benefit or policy is terminated; or
- (iv) on the premium due date coinciding with or next following:
 - (a) the date on which the Policyholder instructs the Plan Administrator in writing to terminate such insurance; or
 - (b) the end of the Grace Period if the Policyholder fails to make a premium payment as required

The termination dates for benefits are specified in the Schedule of Benefits.

The Policyholder's Dependents' benefits terminate at the earliest of the following dates:

- (i) on the date the Policyholder's benefits terminate;
- (ii) on the date the Dependent ceases to be a permanent resident of Canada or be covered under the Government Health Insurance Plan in his/her province or territory of residence; or
- (iii) on the premium due date coinciding with or next following:
 - (a) the date on which the Dependent is no longer considered an eligible Dependent Child or Spouse;
 - (b) the date on which the Policyholder instructs the Plan Administrator in writing to terminate such insurance; or
 - (c) the end of the Grace Period if the Policyholder fails to make a premium payment as required.

The termination dates for benefits are specified in the Schedule of Benefits.

2.6. Cancellation

The Policyholder may cancel this policy at any Premium Due Date by giving written notice to the Plan Administrator. The Insurer may cancel this policy at any Premium Due Date by instructing the Plan Administrator to give thirty (30) days written notice to the Policyholder.

2.7. Change in Coverage

The Policyholder must immediately notify the Insurer in writing, of any event likely to change a Policyholder's insurance coverage, on forms provided for that purpose. Such change takes effect on the actual date of the event. However, in the case where evidence of insurability is required, the change takes effect on the date the Insurer approves the change.

2.8. Misstatement of Age

If the Insured's date of birth has been misstated in the application for coverage under this policy, all benefits payable under this policy will be those that the premium paid would have purchased at the correct age but shall not exceed the Insurer's issue or qualifying limits in effect at that time.

If, because of the misstatement, the Insurer accepts a premium for a period or periods beyond the date coverage would have ceased according to the correct age, or if at the correct age the coverage would not have become effective, the Insurer's liability will be limited to the refund of all premiums paid for the period during which coverage would not

have been in effect. In no event will any adjustment under this provision cause the amount of any benefit to increase over any maximum limit stated in this policy.

2.9. Amendments

No alteration, variation or addition (Amendment) to this policy shall be valid unless provided in writing and signed by an authorized representative of the Insurer. All Amendments will be deemed to be accepted by the Policyholder after payment of premiums for periods beginning on or after the effective date of such Amendment. However, in the event that the Amendment was not a direct result of a request by the Policyholder, the Policyholder will be allowed thirty (30) days from the receipt of the Amendment to question, in writing, any of the revised terms or conditions. In the absence of any written objections, the Amendment shall take effect as prescribed.

No Amendment, renewal or cancellation of this policy shall require the consent of or notice to any Insured or beneficiary or any other person other than the Policyholder.

2.10. Premium

Premiums are due on the Premium Due Date specified in the Schedule of Benefits and are payable to the Plan Administrator. If any cheque, draft, money order or other instrument tendered in the payment or part payment of a premium is not honoured when presented for payment, the premium or such part hereof shall be considered unpaid.

Payment of a premium will not cause coverage to take effect or continue if it would not do so according to the terms and conditions of this policy.

The policy of any one Policyholder cannot be singled out for a premium change after the policy has been in force. However, the Insurer reserves the right to change the premium from time to time due to adverse experience in any particular Class. In this case, the Insurer can change the premium rates upon thirty (30) days written notice to the Policyholder. The Insurer will change premium no more than once a year on April 1st.

Premium can be changed at any time if:

- (i) the policy provisions are changed at the request of the Policyholder;
- (ii) any law or regulation or amendment thereto enacted by any Provincial or Federal Government affects the Insurer's liability under this policy and in the judgement of the Insurer requires a change in premium;
- (iii) there is a change in the amount or type of hospital room or board charges made by eligible institutions;
- (iv) there is a change change in any governmental hospital, medical or dental plan;
- (v) there is a change in any provincial dental fee guide; or
- (vi) there is a change in the Compendium of Pharmaceuticals and Specialities, whether or not such change has been published in a revised Compendium of Pharmaceuticals and Specialities.

The Policyholder must notify the Plan Administrator in writing of any change in occupation or province or territory of residence and the date the change occurred.

The Insurer also reserves the right to change the premium as a result of a change in occupation or upon discovery of any misstatement, misrepresentation or omission relative to an Insured's insurability or a change in the province or territory of residence of the Policyholder to the premium for the Class to which the Policyholder becomes a member or to the appropriate insurable morbidity for the Policyholder.

2.11. Grace Period

After the first premium has been paid, thirty (30) days of grace are allowed to pay any premium payment in default. During this time the policy will stay in force. If the full outstanding premium is not paid by the end of the days of grace, this policy will terminate. There will be no grace period if the Policyholder has already given the Plan Administrator notice to terminate the policy.

2.12. Reinstatement

If any renewal premium is not paid before the Grace Period ends, the policy will terminate. However, the policy may be reinstated with additional evidence of insurability, if application for reinstatement is made within ninety (90) days following the date the first unpaid premium was due. The reinstated policy will only cover losses sustained after the date of reinstatement.

2.13. Payment of Benefits

Eligible expenses incurred by an Insured must be incurred on or after the date his/her coverage comes into effect but before the coverage for him/her expires. The expenses for eligible treatment or services are considered to be incurred only on the date the treatment or service is given.

For prostheses, expenses are considered to be incurred only on the date such prosthesis is installed.

For all other eligible expenses, the expenses are considered to be incurred on the date the item was purchased.

2.14. Subrogation

If any benefits are payable in accordance with the terms of this policy to an Insured, and such Insured has a right to recover damages for any person or organization, then the Insurer will be subrogated to the rights of the Insured and;

1. the Insured will reimburse the Insurer in the amount of any benefits paid under this policy out of the damages recovered from such person or organization, or
2. the Insurer will acquire the rights of recovery of the Insured in the amount of any benefits paid under this policy against such person or organization.

2.15. Currency

All limits and benefits in this policy are in Canadian dollars. All benefit payments made under this policy shall be in Canadian dollars.

2.16. Policyholder’s Co-ordination and Limitation of Benefits

This policy is secondary to all other insurance coverages a Policyholder may have in force. If any benefits payable to a Policyholder under this policy are in addition to similar benefits payable to the Policyholder by any other provider, total benefits paid to the Policyholder by all insurers cannot exceed the Policyholder’s actual total expenses. The maximum to which a Policyholder is entitled is the largest amount specified for the benefit in any one of the provider’s policies. If other insurers, for which a Policyholder has coverage, state they are secondary payors also, the Insurer will co-ordinate payment of benefits with all insurers which provide the Policyholder benefits similar to those provided under this policy, up to a maximum of the largest amount specified by each provider.

2.17. Dependents’ Co-ordination and Limitation of Benefits

Benefits for eligible expenses incurred by a Policyholder’s Dependents who are covered under this policy as well as another plan will be determined on the following basis:

(i) **Spouse**

Where the Policyholder’s Spouse is covered under this policy and covered as a participant under another plan, that portion of an expense which is eligible for reimbursement under such plan will not be payable under this policy. The Policyholder’s Spouse must first file a claim with his/her insurer.

Thereafter, the Policyholder may submit to the Third Party Administrator a reimbursement request for the portion of the expenses not reimbursed by the Policyholder’s Spouse’s insurer but eligible under this policy.

The Policyholder must provide copies of the other insurer claim settlement and of the receipts.

(ii) **Children**

Where the Policyholder’s Dependent Child is covered as a Dependent under this policy and also under the Policyholder’s Spouse’s plan, benefits will first be payable under this policy if the Policyholder’s birth date (month and day) occurs earlier in the calendar year in relation to that of the Policyholder’s Spouse.

Thereafter, the Policyholder’s Spouse may submit to his/her insurer a reimbursement request for the portion of the expenses not reimbursed under this policy but eligible under his/her plan. Copies of the settlement issued by the Third Party Administrator and receipts must be provided.

Should the spouses have the same birth date, the claims for children must then be filed in the alphabetical order of the spouses’ first names.

2.18. Government Plans

When reimbursement is available under a government plan, each eligible expense is reduced by the amount payable under that plan. The reduced eligible expense is then considered to be the eligible expense under all co-ordination of benefit provisions. It is subject to any applicable deduction, percentage of payment any benefit limits under this policy. Government plans are plans that are legislated, funded or administered by a government. Group plans for government employees are not included.

2.19. Subrogation

The Insurer has full rights of subrogation. In the event of a payment of a claim under this policy, the Insurer will have the right to proceed, in an Insured's name, but at the Insurer's expense, against third parties who may be responsible for giving rise to a claim under this policy. An Insured will execute and deliver documents as necessary and cooperate fully with the Insurer so as to allow the Insurer to fully assert their rights. An Insured will do nothing to prejudice such rights.

2.20. Statutory Conditions

Notwithstanding any provisions contained herein, this policy is subject to the Statutory Conditions of the Insurance Act applicable to contracts of accident and sickness insurance in the Insured's province or territory of residence in Canada. This policy is governed by the laws and regulations of the province or territory in Canada in which the Insured resides. Any provision of this policy which is in conflict with any federal, provincial or territorial law of the Insured's province or territory of residence is amended to conform with the minimum requirements of that law, and all other provisions shall remain in full force and effect.

It is a legal requirement that these conditions be reproduced in this policy in the following form. In these statutory conditions loss means a benefit for which a claim is made under this policy.

The Contract

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

Waiver

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

Copy of Application

The Insurer shall, upon request, furnish to the Policyholder or to a claimant under the contract a copy of the application.

Material Facts

No statement made by the Policyholder or person insured at the time of application for this contract shall be used in defence of a claim under or to avoid this contract unless it is contained in the application or any other written statements or answers furnished as evidence of insurability.

Changes in Occupation

1. If after the contract is issued the Policyholder engages for compensation in an occupation that is classified by the Insurer as more hazardous than that stated in this contract, the liability under this contract is limited to the amount that the premium paid would have purchased for the more hazardous occupation according to the limits,

classification of risks and premium rates in use by the Insurer at the time the Policyholder engaged in the more hazardous occupation.

2. If the Policyholder changes his or her occupation from that stated in this contract to an occupation classified by the Insurer as less hazardous and the Insurer is so advised in writing, the Insurer shall either,
 - (a) reduce the premium rate; or
 - (b) issue a policy for the unexpired term of this contract at the lower rate of premium applicable to the less hazardous occupation, according to the limits, classification of risks, and premium rates used by the Insurer at the date of receipt of advice of the change in occupation, and shall refund to the Policyholder the amount by which the unearned premium on this contract exceeds the premium at the lower rate for the unexpired term.

Notice and Proof of Claim

The Policyholder or an Insured, or a beneficiary entitled to make a claim, or the agent of any of them, shall,

- (a) give written notice of claim to the Third Party Administrator or the Plan Administrator, not later than thirty (30) days from the date a claim arises under the contract on account of an accident, sickness or disability;
- (b) within ninety (90) days from the date a claim arises under the contract on account of an accident, sickness or disability, furnish to the Third Party Administrator such proof as is reasonably possible in the circumstances of the happening of the accident or the commencement of the sickness or disability, and the loss occasioned thereby, the right of the claimant to receive payment, his or her age, and the age of the beneficiary if relevant; and
- (c) if so required by the Third Party Administrator, furnish a satisfactory certificate as to the cause or nature of the accident, sickness or disability for which claim may be made under the contract and as to the duration of such disability.

Failure to Give Notice or Proof

Failure to give notice of claim or furnish proof of claim within the time prescribed by this statutory 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 the accident or the date a claim arises under the contract on account of sickness or disability if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

Insurer to Furnish Forms for Proof of Claim

The Third Party Administrator shall furnish forms for proof of claim within fifteen (15) days after receiving notice of claim, but where the claimant has not received the forms within that time the claimant may submit his or her proof of claim in the form of a written statement of the cause or nature of the accident, sickness or disability giving rise to the claim and of the extent of the loss.

Rights of Examination

As a condition precedent to recovery of insurance money under this contract,

- (a) the claimant shall afford to the Insurer an opportunity to examine the person of the Insured when and so often as it reasonably requires while the claim hereunder is pending; and
- (b) in the case of death of the Insured, the Insurer may require an autopsy subject to any law of the applicable jurisdiction relating to autopsies.

When Money Payable Other Than for Loss of Time

All money payable under this contract, other than benefits for loss of time, shall be paid by the Insurer within sixty (60) days after it has received proof of claim.

3. SUPPLEMENTARY HEALTH BENEFITS

3.1. Insuring Agreement

If as a result of accidental injury, illness or pregnancy, an Insured incurs expenses for medically required services, care, treatment and equipment, the Insurer will reimburse the eligible expenses when coverage for these benefits are indicated as included in the Schedule of Benefits, subject to the terms and conditions hereinafter specified.

3.2. Reimbursement

The Insurer reimburses these expenses subject to the Percent of Payment of Eligible Expenses and any benefit amounts specified in the Schedule of Benefits.

3.3. Eligible Expenses

The following expenses for services, care, treatment and supplies are eligible, provided they are medically required, have been incurred in Canada and are not payable or reimbursable under a Government Health Insurance Plan and are indicated as included in the Schedule of Benefits. The maximum amounts reimbursed by the Insurer are specified in the Schedule of Benefits.

3.3.1. Vision Care

3.3.1.1. Eye Examinations

Services of an optometrist or ophthalmologist for eye examinations in accordance with the conditions specified in the Schedule of Benefits.

3.3.1.2. Eyeglasses or Contact Lenses

Purchase of prescription eye glasses or contact lenses provided they have been prescribed by an ophthalmologist or an optometrist, in accordance with the conditions specified in the Schedule of Benefits.

3.3.2. Hospital Accommodations

The Insurer will reimburse that part of Hospital expenses which exceeds the amount reimbursed by Government Health Insurance Plans, in accordance with the conditions specified in the Schedule of Benefits.

3.3.3. Hearing Aids

Purchase of hearing aids or any related devices, including repairs, with the exception of batteries, and professional services provided by a hearing aid acoustician, following the purchase, are reimbursed provided they have been prescribed by an audiologist, speech therapist or Physician, in accordance with the conditions specified in the Schedule of Benefits.

3.3.4. Private Duty Nursing

Private duty nursing services rendered at the Insured's home by a professional practitioner specified in the Schedule of Benefits, for medical services strictly rendered in his/her professional capacity, in accordance with the conditions specified in the Schedule of Benefits.

The practitioner must be unrelated to the Insured and must not ordinarily reside in the Insured's home. The services rendered must be prescribed by a Physician and previously approved by the Third Party Administrator.

3.3.5. Paramedical Practitioners

Services given by a paramedical practitioner specified in the Schedule of Benefits, in accordance with the conditions specified therein.

- (i) The practitioner must be legally authorized by the appropriate provincial or federal body to practice his/her profession within the scope of his/her specialty and not related by blood or marriage to the Insured or ordinary resident with the Insured or a business associate of the Insured.
- (ii) The services rendered must have been previously prescribed by a Physician unless specified otherwise in the Schedule of Benefits.
- (iii) The maximums apply for each specialist, unless specified otherwise in the Schedule of Benefits.
- (iv) X-ray examinations provided by a professional practitioner are eligible, in accordance with the conditions specified in the Schedule of Benefits.

Eligible expenses are limited to one (1) professional visit per day for each type of specialist.

3.3.6. Durable Medical Equipment & Supplies

The following supplies are eligible expenses provided they have been previously prescribed by a Physician:

- (i) Rental or initial purchase, as previously approved by the Third Party Administrator, of a non-motorized wheelchair, crutches, manual hospital bed, respiratory equipment and any other durable medical equipment, excluding batteries and repairs, required on a temporary basis for therapeutic use.
- (ii) Purchase of dressings, casts, oxygen and rental of equipment necessary for its administration, obtained in a specialized establishment or laboratory, duly authorized under provincial regulations, if applicable.
- (iii) Purchase of elastic support stockings specially designed for the treatment of varicose veins, and surgical or other support stockings and surgical sleeves for chronic conditions, limited to two (2) per calendar year. These must be obtained from a specialized establishment or laboratory duly authorized under provincial regulations, if applicable. Both compression-type elastic support

- stockings and surgical stockings are deemed to be elastic support stockings for this purpose. Compression sleeves are included.
- (iv) Purchase of required supplies following an ileostomy or colostomy.
 - (v) Purchase of all diabetic supplies, when insulin must be taken to control diabetes, such as testing equipment (such as "Glucometer®") non-disposable insulin delivery devices (such as "Novolin Pen®") spring loaded devices used to hold lancets, alcohol, alcohol swabs, disinfectants. Insulin pumps are covered in accordance with the conditions specified in the Schedule of Benefits.
 - (vi) Purchase of blood pressure monitor, in accordance with the conditions specified in the Schedule of Benefits.
 - (vii) Purchase of respiratory and Sleep Apnea equipment, in accordance with the conditions specified in the Schedule of Benefits.
 - (viii) Purchase of medical braces, supporting devices or appliances, including repairs, in accordance with the conditions specified in the Schedule of Benefits.
 - (ix) Atomizers, extension devices for inhaled medications (such as "Rotohaler®", "Diskhaler®", "Aerochamber®") or supplies and accessories for the aforementioned.

3.3.7. Prosthetics

The following supplies are eligible expenses provided they have been previously prescribed by a Physician:

- (i) Purchase of prostheses and orthotics such as artificial limb or eye, braces, corsets, hernial supports or other orthopaedic devices, obtained in a specialized establishment or laboratory, provincially licensed where such regulations exist, in accordance with the conditions specified in the Schedule of Benefits. Auditive, breast, capillary, dental or oral prostheses, orthopaedic shoes, podiatric orthotics, podiatric supports, arch supports and corrective devices added to ordinary shoes are not covered herein.
- (ii) Purchase of orthopaedic shoes specially made for the Insured, corrective devices added to ordinary shoes, and podiatric orthotics in accordance with the conditions specified in the Schedule of Benefits. Any such appliances must be obtained from a specialized establishment or laboratory, duly authorized under provincial regulations, if applicable, to provide, manufacture and/or fit such orthopaedic devices and podiatric orthotics. These appliances must be manufactured, dispensed or fitted in conjunction with professionals dealing exclusively with foot or ankle disorders. Such expenses are reimbursed according to the same terms and conditions if the prescription is given by a podiatrist or a chiroprapist.
- (iii) Purchase of breast prosthesis, once per calendar year, required as a result of a mastectomy. The purchase of surgical brassieres to a maximum of two (2) per calendar year. Repairs to prostheses are excluded expenses.

- (iv) Purchase of wigs or hairpieces required as a result of an illness or injury, in accordance with the conditions specified in the Schedule of Benefits

3.3.8. Ambulance Services

Licensed ambulance service for transportation to the nearest Hospital equipped to provide the required treatment, when the physical condition of the Insured precludes the use of any other means of transportation, in accordance with the conditions specified in the Schedule of Benefits.

3.3.9. Accidental Dental

Dental care required as a result of injury to natural teeth provided by a Dentist or specialist, in accordance with the normal suggested fee for a general practitioner, in accordance with the conditions specified in the Schedule of Benefits. The accident must be reported within ninety (90) days.

Only care received within twelve (12) months of the injury is covered. All other dental expenses are excluded.

3.4. Exclusions

This benefit does not cover:

- 3.4.1.** Any treatment or device related directly or indirectly to the full reconstruction of the mouth, to correct vertical dimensions or temporomandibular joint dysfunction.
- 3.4.2.** Any treatment, surgery, care, service examination or device which:
 - (i) is not medically necessary;
 - (ii) is provided or required for cosmetic purposes;
 - (iii) is provided or required in connection with an operation or a treatment conducted as an experiment
 - (iv) is provided or required for non-curative reasons;
 - (v) exceeds what is ordinarily provided or required by current therapeutic practice.
- 3.4.3.** Any portion of the charge for services, care treatment and supplies in excess of the reasonable and customary charge for an illness of the same nature and severity in the area where the services are provided.
- 3.4.4.** Eye examinations, unless otherwise indicated in the Schedule of Benefits.
- 3.4.5.** Prescription, initial purchase, adjustment or replacement of eye glasses or contact lenses, unless otherwise indicated in the Schedule of Benefits.
- 3.4.6.** Prescription drugs or medication.

4. PRESCRIPTION DRUGS BENEFITS

4.1. Insuring Agreement

Benefits for prescription drugs or medications necessitated by accidental injury, illness or pregnancy, will be provided when coverage for these benefits are indicated as included in the Schedule of Benefits, subject to the terms and conditions hereinafter specified.

4.2. Calculation of Amount Payable

The Insurer reimburses a Percentage of Eligible Expenses incurred for the ingredient cost for the lowest priced interchangeable product, regardless of the product actually dispensed, plus the dispensing fee. Prescriptions written and directed by the prescriber not to be interchanged must be dispensed as indicated. Prescriptions must bear the notation "Do Not Product Select", "No Sub", or "No Substitution" on the actual script in the prescriber's own handwriting in order to be eligible for payment above the cost for the lowest priced interchangeable product. The Percentage of Eligible Expenses and benefits amounts are specified in the Schedule of Benefits.

4.3. Eligible Expenses

Expenses incurred by the Insured for prescription drugs or medications are eligible, provided they are incurred in Canada.

4.4. Eligible Drugs and Medications

4.4.1. Prescriptions Requiring Drugs

Prescribed drugs and medications bearing a Drug Identification Number as defined by the Food and Drug Act, Canada (DIN) and listed as prescription requiring in Federal or Provincial Drug Schedules.

4.4.2. Injectable Drugs

Selected injectable drugs, injectable vitamins, insulin, and non patient specific allergy extracts bearing a DIN.

4.5 Dispensing Limitations

The quantity of a prescription drug dispensed is the lesser of the quantity prescribed or a ninety (90) day supply. However, first time prescriptions are limited to a thirty (30) day trial supply.

4.6 Exclusions

This benefit does not cover:

4.6.1 Oral erectile dysfunction drugs, smoking cessation products, anti-obesity drugs or medications and/or compounds deemed to be fertility drugs unless otherwise specified in the Schedule of Benefits.

4.6.2 Disposable needles, disposable syringes, lancets and chemical reagent testing materials used for insulin administration and monitoring in diabetes.

- 4.6.3** Items deemed cosmetic, such as topical Minoxidil or sunscreens, even if a prescription is legally required, whether or not such a prescription is given for medical reasons.
- 4.6.4** Atomizers, appliances, prosthetic devices, colostomy supplies, first aid kits or equipment, electronic diagnostic monitoring or testing equipment (such as "Glucometer®") non-disposable insulin delivery devices (such as "Novolin Pen®") delivery or extension devices for inhaled medications (such as "Rotohaler®", "Diskhaler®", "Aerochamber®") spring loaded devices used to hold lancets, alcohol, alcohol swabs, disinfectants, cotton, bandages, or supplies and accessories for the aforementioned.
- 4.6.5** Oral vitamins, minerals, dietary supplements, infant formulas or injectable total parenteral nutrition (TPN) solutions, whether or not such a prescription is given for a medical reason, except where Federal or Provincial law requires a prescription for their sale.
- 4.6.6** Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, non-medical intrauterine devices (IUDs), contraceptive implants or appliances normally used for contraception whether or not such a prescription is given for a medical reason.
- 4.6.7** Herbal and homeopathic preparations, even if combined with a prescription requiring medicine or with a product considered to be eligible.
- 4.6.8** Any medication available over the counter, even when prescribed by a Physician or a Dentist.
- 4.6.9** All preventative immunization vaccines and toxoids.
- 4.6.10** All patient specific allergy extracts, compounded in a laboratory, and not bearing a DIN.
- 4.6.11** Any medications or drugs that are reimbursed by either the applicable Provincial Drug Benefit Plan or a Federal Program.
- 4.6.12** Products not bearing a valid Health Canada issued DIN.
- 4.6.13** Consultation charges and/or professional fees rendered by a Physician, Pharmacist (other than dispensing fees) or registered nurse.
- 4.6.14** Extemporaneous compound preparations
- 4.6.15** There is no coverage for any drug, biological or related preparations which:
 - (i) does not meet accepted standards of medical, dental or ophthalmic practice or is not considered to be effective (either medically or from a

- cost perspective, based on Health Canada's approved indication for use);
- (ii) are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home;
 - (iii) does not require a prescription and is not dispensed by an accredited pharmacist;
 - (iv) is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries;
 - (v) is not legally available for sale in Canada.
 - (vi) require pre-authorization, if such pre-authorization is not obtained.

5. DENTAL CARE BENEFITS

5.1. Insuring Agreement

The Insurer undertakes to reimburse dental care expenses, incurred by an Insured in his/her province or territory of residence, when coverage for these benefits are indicated as included in the Schedule of Benefits, subject to the terms and conditions hereinafter specified.

5.2. Fees

Expenses incurred may not exceed the reimbursement basis in accordance with the Suggested Fee Guide for Dental Services provided for general practitioners, approved and published by the Dental Surgeon Association of the province or territory where the services were rendered, and for the year of reference of publication specified in the Schedule of Benefits.

If Orthodontic Services are indicated as included in the schedule of Benefits and an orthodontist sets a global fee at the beginning of a treatment expected to extend beyond a year, the Insurer reserves the right to spread such fee over the entire treatment period and to reimburse expenses periodically throughout the treatment.

5.3. Payment of Benefits

5.3.1. Required Proof

Before paying benefits, the Third Party Administrator may require, as proof and at no expense to the Insurer, a complete diagram showing the covered person's state of dentition prior to the beginning of the treatment for which a claim is submitted. The Third Party Administrator may also, if deemed necessary, require laboratory or hospital reports, X-rays, casts, molds or models used for examination purposes, or any other similar evidence.

5.3.2. Alternative Treatment Plan

If more than one (1) type of treatment exists for the dental condition of the Insured, the Insurer reimburses the lesser fee, provided however that the treatment given is normal and appropriate.

5.4 Treatment Plan

If the total cost of a treatment is expected to exceed the amount specified in the Schedule of Benefits, a Treatment Plan must be submitted to the Third Party Administrator, who will determine, before commencement of treatment, the amount of expenses to be covered.

“Treatment Plan” means a written description of the treatment which, in the opinion of the Dentist, will be required, including X-rays in support of such opinion, the probable date of treatment and the expected cost.

Even if a Treatment Plan has been submitted to, and approved by, the Third Party Administrator, expenses are considered to be incurred only when treatment has actually been given during the period the coverage is in effect.

5.5 Late Applicants

If a Dependent becomes insured more than thirty (30) days after first becoming eligible for dental insurance, the maximum amount payable for all dental benefits shall not exceed one hundred dollars (\$100) during the first twelve (12) months of coverage.

5.6 Calculation of Amount Reimbursable

The Insurer reimburses the eligible expenses subject to the Percentage Payment of Eligible Expenses and the benefit amounts specified in the Schedule of Benefits.

5.7 Eligible Expenses

The following expenses are covered only when coverage for such services are indicated as included in the Schedule of Benefits.

5.7.1 Expenses for Preventive Treatments

Expenses for the following preventive treatments are eligible:

5.7.1.1 Examination And Diagnosis

- (i) Oral examination, as specified in the Schedule of Benefits
- (ii) Recall oral examination, as specified in the Schedule of Benefits
- (iii) Emergency oral examination
- (iv) Specific oral examination

5.7.1.2 Radiographs

- (i) Intraoral — Periapical, one complete series every two years
- (ii) Intraoral — Occlusal
- (iii) Intraoral — Bitewing, once every twelve (12) months
- (iv) Extraoral
- (v) Sialography
- (vi) Panoramic, once every five (5) years
- (vii) Radiopaque dyes
- (viii) Cephalometric film

5.7.1.3 Tests and Laboratory Examinations

- (i) Microbiologic culture
- (ii) Caries susceptibility tests
- (iii) Biopsy of oral tissue — Soft
- (iv) Biopsy of oral tissue — Hard
- (v) Cytologic smear
- (vi) Pulp vitality tests

5.7.1.4 Preventative Services

- (i) Prophylaxis, as specified in the Schedule of Benefits

- (ii) Preventive recall packages, as specified in the Schedule of Benefits
- (iii) Fluoride treatments once every nine (9) months for Insureds under age nineteen (19)
- (iv) Initial oral hygiene instruction

5.7.2 Expenses for Basic Treatments

Expenses for the following basic treatments are eligible:

5.7.2.1 Other Basic Treatment

- (i) Finishing restorations
- (ii) Pit and fissure sealant, for Insureds under age fifteen (15).
- (iii) Caries, trauma and pain control
- (iv) Interproximal discing

5.7.2.2 Space Maintainers

Space maintainers for loss of primary teeth, for Insureds under age eighteen (18)

5.7.2.3 Control of Harmful Habits

Appliances to control harmful habits for children

5.7.2.4 Restorative Services

- (i) Amalgam restorations, limited to once every two (2) years on the same tooth surface.
- (ii) Acrylic or composite resin restorations
- (iii) Restorations prefabricated, metal or plastic
- (iv) Recement inlay or crown
- (v) Removal of inlay or crown

5.7.2.5 Endodontics

- (i) Pulpotomy
- (ii) Pulpectomy
- (iii) Root canal therapy for permanent teeth, limited to one course of treatment per tooth. Repeat treatment is covered only if the original therapy fails after the first three (3) years.
- (iv) Periapical services
- (v) Apexification
- (vi) Other endodontic procedures

5.7.2.6 Periodontics

- (i) Non surgical services
- (ii) Surgical services
- (iii) Periodontal splinting
- (iv) Adjunctive periodontal procedures
- (v) Scaling/root planing, combined limit of units as specified in the Schedule of Benefits. A "unit" is considered to be a

fifteen (15) minute interval or any portion of a fifteen (15) minute interval.

5.7.2.7 Prosthodontics—Removable

- (i) Adjustments, repairs, additions
- (ii) Relining and rebasing, limited to one standard relining or rebasing in any period of three (3) years.

5.7.2.8 Prosthodontics — Fixed

Repairs

5.7.2.9 Oral Surgery

- (i) Uncomplicated removals
- (ii) Surgical removals
- (iii) Minor alveoplasty
- (iv) Gingivoplasty and stomatoplasty
- (v) Surgical excision
- (vi) Surgical incision and drainage
- (vii) Frenectomy
- (viii) Hemorrhage control

5.7.2.10 Adjunctive General Services

Anaesthesia only in relation to surgery

5.7.3 Expenses of Major Treatment

Expenses for the following major treatments are eligible:

5.7.3.1 Prosthetics — Initial

The initial, complete or partial, fixed or removable prostheses.

5.7.3.2 Prosthetics — Replacement

Replacement of, complete or partial, fixed or removable prostheses, in the case of:

- (i) Replacement following the extraction of natural teeth.
- (ii) Replacement of a prosthesis that is at least the age specified in the Schedule of Benefits and can no longer be used.
- (iii) Initial replacement of a temporary prosthesis fitted less than twelve (12) months before.

In no event will the coverage cover lost or stolen prostheses.

Whenever laboratory fees are incurred, they shall be limited to sixty percent (60%) of the fixed fee determined for the procedure, unless justified by a receipt furnished by a commercial laboratory.

5.7.3.3 Restorative

- (i) Diagnostic casts
- (ii) Gold foil restorations, if other substances are inappropriate
- (iii) Metal inlay restorations
- (iv) Porcelain inlay restorations, if other substances are inappropriate
- (v) Onlay restorations
- (vi) Pins for inlays, onlays or crowns
- (vii) Post and cast metal cores
- (viii) Crowns
- (ix) Crowns on implants
- (x) Restorative procedure on Implants
- (xi) Veneers, laboratory processed
- (xii) Overdentures

5.7.3.4 Prosthetics — Removable

- (i) Complete dentures
- (ii) Complete dentures on Implants
- (iii) Partial dentures

5.7.3.5 Prosthetics — Fixed

- (i) Bridge pontics
- (ii) Retainers and abutments
- (iii) Other prosthetic services

5.7.3.6 Oral Surgery

- (i) Treatment of fractures
- (ii) Other oral surgery

5.8 Exclusions

This benefit does not cover:

- 5.8.1** Treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension and temporomandibular joint dysfunction or for the replacement of lost, misplaced or stolen appliance or dentures.
- 5.8.2** Dental services not included in the list of eligible expenses.
- 5.8.3** Surgical services in relation to implants.
- 5.8.4** Upgrading an existing applicant that was provided under this policy.
- 5.8.5** Services rendered by a dental hygienist and not administered under supervision of a Dentist.
- 5.8.6** Dental services covered under the Supplementary Health Benefits, if such benefits are part of this policy, or under any other group insurance contract.



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5.8.7 Veneers, recontouring existing crowns or staining porcelain.

5.8.8 Custom fluoride appliances.

5.8.9 Orthodontic treatment

6. GENERAL EXCLUSIONS

This policy does not cover:

- 6.1.** Expenses which are or would normally be payable or reimbursable under a private or public insurance plan.
- 6.2.** Suicide or attempted suicide or self-inflicted injury, while sane or insane.
- 6.3.** Periodic health examinations, broken appointments, Physician's costs for travelling or providing telephone advice, third party examinations, completion of forms or medical reports, travel for health purposes.
- 6.4.** Injury or illness resulting from civil unrest, insurrection or war, whether war has been declared or not, participation in a riot or any Acts of Terrorism, political instability or Nuclear Occurrence.
- 6.5.** Care or services rendered free of charge or which would be free of charge were it not for coverage or which are not chargeable to the Insured.
- 6.6.** Services and supplies relating to any appliance worn in the practice of a sport.
- 6.7.** The replacement of eye glasses or lenses which have been lost, stolen or broken; the cost of fitting lenses or glasses; sunglasses, monogrammed or special frames and non-prescription lens tint and industrial safety glasses except those which are specifically recommended by the attending physician for the use in place of regular prescription glasses or lenses.
- 6.8.** Services which are not medically required, which are given for cosmetic purposes or which exceed ordinary services given in accordance with current therapeutic practice.
- 6.9.** Experimental medical treatments or medical treatments not approved by Health Canada.
- 6.10.** Services or treatments that are covered under a Canadian Government Health Insurance Plan.
- 6.11.** Expenses that are prohibited by law from being covered by a private insurance plan.
- 6.12.** Hospital confinement in an intensive care unit, coronary care unit, coronary surgical unit, labour/delivery or case room.
- 6.13.** Expenses for rest cures, travel for health reasons, periodic health check-ups or examinations for use by a third party.
- 6.14.** Services provided in a health spa, chronic care or psychiatric hospital or chronic care unit of a general Hospital, except as provided under this policy.
- 6.15.** Services or supplies provided while confined to a nursing home or a home for the aged.

- 6.16.** Sickness caused by or resulting from Human Immunodeficiency Virus (H.I.V.), Acquired Immune Deficiency Syndrome (AIDS), or any AIDS related disease if the condition was diagnosed or known prior to the date of the application for this policy.
- 6.17.** For additional, duplicate or replacement appliances or devices, except where the replacement is required because the existing appliance can no longer be made serviceable due to normal wear and tear or as a result of a pathological change, subject to the prior approval of the Third Party Administrator.
- 6.18.** Losses that result from committing or attempting to commit a criminal or illegal act or operating a motor vehicle while impaired by drugs or alcohol (above the legal limit in the jurisdiction where the offence took place).
- 6.19.** Charges incurred outside an Insured's province or territory of residence but within Canada, which exceed the amount payable for the same services when rendered within the Insured's province or territory of residence. There are no benefits for expenses incurred outside of Canada.

7. CLAIMS PROCEDURES

A Policyholder must submit a claim and provide satisfactory proof within the time limit specified hereafter. Claims must be submitted either through accepted electronic network or on the appropriate forms, which must be completed in full, dated and signed. Claims must be submitted to the Third Party Administrator, as applicable, at no expense to the Insurer. Claim forms and information necessary to submit a claim are available from the Plan Administrator or the Third Party Administrator.

For the purposes of determining the validity of a claim under this policy, the Insurer may obtain and review the medical records of the Insured's attending Physician(s), including the records of the Insured's regular Physician(s) at home. These records may be used to determine the validity of a claim whether or not the contents of the medical records were made known to the Insured before the Insured incurred a claim under this policy. In addition, the Insurer has the right, and the Insured shall afford the Insurer the opportunity, to have the Insured medically examined when and as often as may reasonably be required while benefits are being claimed under this policy. If the Insured dies the Insurer has the right to request an autopsy, if not prohibited by law.

All benefits are payable to the Insured. If the Insured dies all benefits are payable to his/her estate or beneficiary if indicated.

No amounts payable under this policy shall carry interest.

The Insurer, Plan Administrator, Third Party Administrator or any company or agency providing services on their behalf is not responsible for the quality, availability, results or effects of any treatment, services, transportation or the Insured's failure to obtain such treatment, services or transportation.

Please note that incomplete documentation will be returned to the Insured for completion. Once the Third Party Administrator or receives the Insured's claim, the Insured may be required to provide additional information. Failure to submit required information will lead to a delay in processing the claim.

7.1. Supplemental Health Benefits

Claims must be received by the Third Party Administrator not later than twelve (12) months from the date that the expense is incurred. However, if coverage for a Policyholder is terminated, including termination of the benefit or policy, all claims must be received by the Third Party Administrator not later than three (3) months following the termination date. If applicable law provides for a longer period, the Insured must submit his/her claim within the longer period provided by law. All claims received by the Third Party Administrator following these time periods will be declined.

7.2. Prescription Drug Benefits

For eligible prescription drugs, the Policyholder may use the pay direct drug card every time he/she has a prescription filled in a participating pharmacy that accepts the card. With the pay direct drug card, the Policyholder's prescription drug claims are settled in the pharmacy. When the Insured incurs an eligible expense at a participating

pharmacy, the Pharmacist will submit the claim electronically to the Third Party Administrator for adjudication. The Pharmacist will then immediately inform the Insured of the reimbursement amount to which he/she is entitled and of the amount he/she must disburse, if any.

However, when an Insured incurs an eligible expense at a non-participating pharmacy, he/she must submit a completed claim form provided for that purpose along with original receipts directly to the Third Party Administrator, twelve (12) months from the date that the expense is incurred. However, if coverage for a Policyholder is terminated, including termination of the benefit or policy, all claims must be received by the Third Party Administrator not later than three (3) months following the termination date. If applicable law provides for a longer period, the Insured must submit his/her claim within the longer period provided by law. All claims received by the Third Party Administrator following these time periods will be declined.

7.3. Dental Care Benefits

Claims must be received by the Third Party Administrator not later than twelve (12) months from the date that the expense is incurred. However, if coverage for a Policyholder is terminated, including termination of the benefit or policy, all claims must be received by the Third Party Administrator not later than three (3) months following the termination date. If applicable law provides for a longer period, the Insured must submit his/her claim within the longer period provided by law. All claims received by the Third Party Administrator following these time periods will be declined.

7.4. Limitation of Actions

An action or proceeding against the Insurer for the recovery of a claim under this contract shall not be commenced more than one (1) year (three (3) years in Quebec) after the date the insurance money became payable or would have become payable if it had been a valid claim.

8. PRIVACY

The Insurer, the Plan Administrator, the Third Party Administrator and any other contracted third parties of the Insurer (We) respect an Insured's privacy and are committed to protecting it. We collect, use and disclose the personal information, which an Insured or the Policyholder gives for the purposes of providing them with insurance services. An Insured's information may be disclosed to others in the medical, investigative and insurance fields as necessary to underwrite and administer this policy and pay benefits. The Insurer may use agents, brokers and service providers to collect, use, store and/or process personal information and personal health information on its behalf, and such information may be transferred to these entities for the purposes described above. Personal information or personal health information may be collected, used, disclosed, transferred, stored or processed outside of Canada and may therefore be subject to legal requirements in such foreign countries. Full details of the Insurer's privacy policy may be accessed at www.echelon-insurance.ca.



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