ANAHITA INSURANCE

Underwritten by Anahita Insurance Corporation ('the Insurer')
2nd Floor, CGI Tower, Warrens, St.Michael, BB22026, Barbados
via Freedom Health Insurance Limited ('the Coverholder')
3 Bourne Gate, 25 Bourne Valley Road, Poole, Dorset, BH12 1DY,
United Kingdom

# Certificate of Insurance

| | |
|---|---|
| **Policyholder name:** | **Policy number:** |
| **Policyholder address:** | **Policy Effective Date:** |
| | **Policy Term:**<br>Both days inclusive, local standard time at the address of the Policyholder. |
| **Annual premium** | |
| **Geographical area of cover** | **Canada** |
| **Currency of the policy** | **Canadian Dollars** |

**Insured Persons**

| Name | Date of Birth | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Endorsements**

| Name | Endorsement(s) |
|---|---|
| | |
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| | |
| | |

**Broker/Plan Sponsor**

| |
|---|
| **Name: Health Risk Services**<br>**#50, 12221 – 44th Street S.E. Calgary, Alberta T2Z 4H3**<br>**403-236-9430 OR 1-877-236-9430** |
| **Product**<br>seCUREme |

**Summary of elected benefits:**

| | |
|---|---|
| Major Medical Benefits: | seCUREme Catastrophic plan |
| Prescription Drugs plan: | Option 1 – 80% reimbursement up to a maximum of $100,000 CAD<br>Option 2 – 100% reimbursement up to a maximum of $100,000 CAD |
| Optional Vision Care: | Included – maximum of $250 CAD per Insured Person every 24 months.<br>Excluded |
| Dental Care: | Basic care services are reimbursed at 80%<br>Major care services are reimbursed at 50% and is subject to a nine month waiting period<br>Overall maximum of $1,250 CAD per Insured Person per Policy Term for all Dental Care expenses. |
| Optional Orthodontics: | Included – costs are reimbursed at 50% up to a maximum opf $2,000 CAD for the lifetime of the policy. Cover only available to dependent children under 19 years of age and is subject to a nine month waiting period.<br>Excluded |
| Overall Maximum Limit | $1,000,000 CAD |
| Emergency medical expenses whilst outside of Canada | 100% of costs up to a maximum of $100,000 CAD for trips of up to 30 days in duration with an aggregate maximum of 90 days per Insured Person per Policy Term |
| Deductible | $2,500 CAD / $5,000 CAD / $10,000 CAD |
| Optional Accidental Death and Dismemberment (AD&D) | Included – Principal Sum is $100,000 CAD<br>Excluded |

**Insuring agreement**

The Policy is a legal contract between the Insurer and the Policyholder where the Insurer agrees with the Policyholder to reimburse up to the limits detailed in this Policy for costs incurred during the Policy Term subject to all of the exceptions, limitations and provisions of this policy. If the Insurer does not enforce, or delays in enforcing, any Policy exception, limitation or provision, this will not prevent the Insurer from enforcing that exception, limitation or provision later.

**Effective date and policy term**

This Policy takes effect on the effective date stated above, at 12.01 A.M., Standard Time at the Policyholder's address, and shall continue in effect as long as the premium is paid as herein agreed, unless and until either the Policyholder or the Insurer terminates the Policy in accordance with the provision entitled "Policy Termination by the Policyholder or the Insurer". Policy Terms and Policy anniversaries shall be determined from the Policy date of issue that shall fall upon the first day of the calendar month and year specified above.

The Insurer reserves the right to change the applicable premium rates but no such change shall affect payment of any premium until the Policy anniversary date next following by not less than thirty one (31) days after the Insurer has mailed or delivered to the Policyholder written notice of such change.

The insurance contract consists of this Declarations page, as well as all coverage wordings, riders or Endorsements that are attached hereto.

**Identification of Insurer**

This insurance has been affected in accordance with the authorization granted to the Coverholder by the Insurer. Any notice to the Underwriter may validly be given to the Coverholder.

**Signature**

In witness whereof this policy has been signed as authorised by the Insurer:

| | |
|---|---|
| **Signed:** | **Date:** |

The Policyholder is requested to read this policy, and if incorrect, return it immediately for alteration. In the event of an occurrence likely to result in a claim under this insurance, immediate notice should be given to the Claims Administrator. All other enquiries and disputes are to be addressed to the Coverholder via the Broker.

# Policy terms and conditions

## 1. Definitions

For the purpose of these terms and conditions the following definitions shall apply:

**Accident**
Any sudden and unforeseen event occurring during the Policy Term, resulting in bodily injury, the cause or one of the causes of which is external to the Insured Person's own body and occurs beyond the Insured Person's control.

**Application Form**
The application for cover under this Policy completed by an Insured Person.

**Assistive Medical Device**
Any item of Durable Medical Equipment that is designed, made, or adapted to help a person with a physical disorder to perform actions, tasks and activities.

**Benefits**
Any covered expenses/services that the Insurer will pay under this Policy.

**Biological agent**
Any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which cause illness and/or death in humans, animals or plants.

**Broker**
The broker acting on behalf of the Policyholder as shown in the Certificate of Insurance.

**Certificate of Insurance**
The document issued to the Policyholder upon acceptance of an Application Form detailing the particulars of this Policy and which should be read in conjunction with these Policy Terms and Conditions.

**Chemical agent**
Any compound which, when suitably disseminated, produces incapacitating, damaging or lethal effects on people, animals, plants or material property.

**Chronic Condition**
Any Injury or Sickness which requires medical attention, monitoring or treatment for a period exceeding ninety (90) consecutive days.

**Claims Administrator**
Health Risk Services.

**Coverholder**
Freedom Health Insurance which is authorised to administer this policy on behalf of the Insurer.

**Daypatient**
A patient who occupies a Hospital bed or is charged for a Hospital bed.

**Declaration**
The declaration made by an Insured Person(s) in the Application Form.

**Deductible**
The amount the Insured Person is liable for before any remaining eligible expenses are reimbursed under this Policy. The amount of the Deductible is shown on the Certificate of Insurance and applies per Insured Person per Policy Term.

**Dentist**
A legally licensed medical practitioner recognised by the law of the country where treatment is provided and who, in rendering such treatment, is practising within the scope of his/her licensing and training. A Dentist must not be the Insured Person or an Immediate Family Member of an Insured Person.

**Dependent**

- The spouse or common law spouse (including same sex) of a Policyholder (but excluding those legally separated) and under the age of 70.
- Unmarried children, step-children, foster children and legally adopted children, who are dependent on the Policyholder for support, provided that such children are not more than 18 years old at the date the Policy was purchased, or 25 years old provided it can be proven that the child is continuing in full-time education. Benefits will terminate at the end of the school term in which the child turns age 25.
- Unmarried children, step-children, foster children and legally adopted children, who are dependent on the Policyholder for support due to physical or mental disability.

**Diagnostic Services**
Laboratory tests and x-ray services, radiographs and nuclear medicine procedures used to diagnose and treat medical conditions.

**Durable Medical Equipment**
Equipment which:

- is primarily and customarily used to serve a medical purpose;
- is generally not useful to a person in the absence of Sickness or Injury; and,
- is appropriate for use in a patient's home.

*Please refer to Schedule A for a listing of items classified as Durable Medical Equipment.*

**Effective Date**
The date on which the coverage under this Policy begins.

**Emergency**
A sudden and unexpected turn of events or change of condition which requires immediate medical treatment and which first manifests itself while this Policy is in force as to the Insured Person.

**Endorsement**
Any change to the Policy terms and conditions as shown on the Certificate of Insurance. This can take the form of:

- a specific Pre-Existing Condition not being covered;
- an extra premium to cover a Pre-Existing Condition (this must be agreed by the policyholder); or
- any other change to the standard terms and conditions

The Policyholder can ask us to reconsider any Endorsement within the first 30 days of each Policy Term.

**Hospital**
Any medical or surgical institution which is legally licensed in the country in which it is located and whose main activities are not those of a rehabilitation centre, spa, hydro clinic, sanatorium, nursing home or home for the aged. It must be under the constant supervision of a resident Physician.

**Hospital Services**
Charges for accommodation, nursing, operating theatres, drugs, dressings, Diagnostic Services or any other Medically Necessary charges made by the Hospital for medical treatment.

**Immediate Family Member**
The spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandson, granddaughter, grandfather or grandmother of the Policyholder.

**Injury**
An unexpected and unforeseen harm to the Insured Person’s body caused by an Accident occurring while this Policy is in force and resulting, directly and independently of all other causes, in the Insured Person incurring Medical Expenses.

**Inpatient**
A patient who occupies a Hospital bed for more than 24 hours for medical treatment and for which admission was recommended by a Physician or Surgeon.

**Insured Person / You / Your**
An eligible person as defined in the eligibility section of this Policy and listed on the Certificate of Insurance.

**Insurer / we / us / our**
Anahita Insurance Corporation.

**Medical Expenses**
Medical and related expenses for which coverage is provided under the Major Medical Benefits section of this Policy which are necessarily incurred as a result of Injury or Sickness while coverage is in force under this Policy as to the Insured Person.

**Medically Necessary**
Any health care service or procedure that a qualified health provider would provide to a patient for the purpose of preventing, diagnosing or treating any illness, disease, injury or its symptoms in a manner that is a) prescribed in accordance with generally accepted standards of care, b) clinically appropriate in terms of type, frequency, extent, site and duration, c) not primarily for the convenience of the patient and d) within the scope of practice of such practitioner.

**Nurse Practitioner (NP)**
A registered nurse who is prepared, through advanced education and clinical training, to provide a wide range of preventive and acute health care services to individuals of all ages.

**Outpatient**
An Insured Person who receives treatment, including Diagnostic Services, at a Hospital or other medical institution or at a Physician's office where the Insured Person is not admitted or confined to a Hospital bed as an Inpatient or Daypatient.

**Overall Maximum Limit**
The total aggregate lifetime limit that may be claimed by an Insured Person as stated in the Certificate of Insurance.

**Physician** or **Surgeon**
A legally licensed medical practitioner recognised by the law of the country where treatment is provided and who, in providing such treatment, is practising within the scope of his / her licensing and training. A Physician or Surgeon must not be the Insured Person or an Immediate Family Member.

**Physician's Assistant (PA)**
A medical professional who works as part of a team with a Physician or Surgeon, is a graduate of an accredited PA educational program and is nationally certified and licensed to practice medicine with the supervision of a Physician or Surgeon.

**Policy**
This Policy / contract of insurance with the Policy number stated on the Certificate of Insurance

**Policyholder**
The holder of this Policy as stated on the Certificate of Insurance.

**Policy Term**
As stated on the Certificate of Insurance.

**Pre-Existing Condition**

Means:

a) a condition for which an Insured Person is given medical care, advice, Diagnostic Services or treatment twelve (12) months prior to the Insured Person's Effective Date of coverage or the Effective Date of any Benefit that is added to existing coverage; or

b) a condition for which an Insured Person is given medication twenty four (24) months prior to the Insured Person's Effective Date of coverage or prior to the Effective Date of any Benefit that is added to existing coverage; or

c) a condition which produced symptoms twenty four (24) months prior to the Insured Person's Effective Date of coverage or the Effective Date of any Benefit that is added to existing coverage. These symptoms must be distinct and significant enough to establish onset or manifestation by one of the following tests:

   i) the symptoms would allow a Physician or Surgeon to make a diagnosis of the disorder; or

   ii) the symptoms would cause an ordinarily prudent person to seek medical diagnosis or treatment.

**Premium Due Date**
Means the date on which the Policy falls due for renewal.

**Reasonable and Customary Costs**
Costs incurred for approved, eligible treatment or supplies that do not exceed the standard costs of other providers of similar standing in the same region, for the same treatment of a similar Sickness or Injury.

**Sickness**
Any unexpected and unforeseen illness or disease manifesting itself while this Policy is in force as to the Insured Person and which causes the Insured Person to incur Medical Expenses.

**Terrorism (nuclear, chemical and biological)**
An act or series of acts, including the use of force or violence or the use of any nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical Agent and/or Biological Agent during the Policy Term by any person or group(s) of persons, whether acting alone, or on behalf of, or in connection with any organization(s) or government(s), committed for political, religious or ideological purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear.

## 2. Eligibility

**Policyholder**
For the purposes of this Policy, the Policyholder must be:

- a Canadian resident and holder of a Canadian passport;
- aged under 70 at time of completing an Application Form for cover;
- have completed and signed the Application Form in acceptance of the Policy terms and conditions; and
- have paid the required premium.

**Dependants**
For the purposes of this Policy, Dependants shall be considered as those persons who are:

- eligible Dependants of the Policyholder (as defined by this Policy under the definitions section) and
- have paid the required premium or had such premium paid on their behalf by the Policyholder.

Newborn children shall be covered up to the age of three (3) months at which time evidence of insurability and the appropriate premium adjustments will be made.

### 2.1 Grandfathering

Persons currently insured under another group insurance or individual insurance plan can enrol under the Health Risk 'Catastrophic' plan with no evidence of insurability provided a declaration of continued good health is received. Persons who qualify to have the Pre-existing Conditions clause waived will be subject to any previous restrictions in place at the time cover was transferred until the earlier of the following:

- if a previous plan of coverage had no pre-existing provision then there shall be no time limit imposed on the cover provided by this Policy; or.
- if the previous plan included a pre-existing provision then such provision will remain in effect under this seCUREme Policy until such time as the provision expires.

Application must be made within thirty (30) days from termination of the previous coverage and the minimum term of coverage is three (3) months. Applications not completed within (thirty) 30 days from the termination of previous coverage will be subject to full medical underwriting and any applicable exclusions the Insurer may apply.

**3. Premium Payment**

The Policyholder undertakes that the premium will be paid, in full, to the Insurer within thirty (30) calendar days of the Effective Date of this Policy or, in respect of instalment premiums, when due.

If the premium due under this Policy has not been paid to the Insurer by the 30th day from the Effective Date of this Policy or, in respect of instalment premiums, by the date it is due, the Insurer shall have the right to cancel this Policy by notifying the Policyholder, in writing, via the Broker. In the event of cancellation, premium is due to the Insurer on a pro rata basis for the period the Insurer is on risk but the full Policy premium shall be due to the Insurer in the event of a loss or occurrence prior to the cancellation date which gives rise to a valid claim under this Policy.

It is agreed that the Insurer shall give not less than thirty (30) days' prior notice of cancellation (the **Notice Period**) to the Policyholder via the Policyholder's Broker. If the premium due is paid in full to the Insurer before the Notice Period expires, notice of cancellation shall automatically be revoked. If not, the Policy shall automatically terminate at the end of the Notice Period.

Premiums are billed as followed:

- Should an Insured Person's cover become effective on the first of the month, premiums will be due for the entire month.
- Should an Insured Person's cover terminate after the first of the month, premiums will be charged for the entire month.
- Premium rates charged are based on the actual birth date and age of the Insured Person at the time the invoice for premium is issued.

**3.1 Currency**

All premium payments made to the Insurer will be in lawful Canadian currency.

## 4. How to make a claim

The Insurer will pay Benefits provided that:

- the Insured Person has contacted and received pre-authorisation of any costs to be incurred either as a Daypatient or an Inpatient. In an Emergency, when the Claims Administrator cannot be contacted in advance, then the admission to Hospital must be reported to the Claims Administrator within no more than forty-eight (48) hours.
- written details of all claims have been sent to the Claims Administrator as soon as possible and in any event not later than ninety (90) days after the occurrence or commencement of any loss covered by the Policy.
- all documentation relating to the claim, including the claim form and invoices, are originals and not copies.
- The required premiums have been paid relative to the Insured Person making the claim.

It is understood by the Policyholder that:

- the Insurer can ask for medical information from any Physician or Surgeon as often as required and, if necessary, examine the Insured Person.
- the Insurer shall be notified of any circumstances that may lead to a claim against a third party or any other insurance policy.

In the event of a non-Emergency claim please contact the Claims Administrators:

Health Risk Services
12221 44 Street SE #50
Calgary AB
T2Z 4H3
Canada
Phone: 403-236-9430
Fax: 403-236-9420
Email: CarrieAnnTempleton@healthrisk.ca

### 4.1 24 Hour Emergency Service Company

In the event of Injury or Sickness resulting in Emergency hospitalisation, the Claims Administrator must be contacted immediately following such hospitalisation.

### 4.2 You must have the following information available:

1) The Policy Number as shown in the Certificate of Insurance.
2) The Insured Person's name and address at that time.
3) The telephone number from which you are calling and can be reached at.
4) The name and telephone number of the Physician and Hospital attending you.
5) Nature of the Emergency.

Failure to contact the Claims Administrator and obtain authorisation may prejudice the claim and mean that not all the costs involved will be paid. The Insured Person should not attempt to find their own solution and then expect full reimbursement from the Insurer without prior approval first having been obtained from the Claims Administrator.

### 4.3 Failure to give notice of proof

Failure to give notice of claim or furnish proof of claim within the time prescribed by this provision 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 ninety (90) days from the date of the Injury or the date a claim arises under the Policy if it is shown that it was not reasonably possible to give notice or furnish proof within the time prescribed.

## 5. Administration of the Policy

The Insurer may employ agents to perform any administrative, management or other ancillary services required to enable the Insurer to perform its obligations under the Policy.

Requests and instructions will only be valid if made or given in writing to the Insurer via the Coverholder.

Any notice given, or other communication, by the Insurer in connection with the Policy Terms and Conditions will be given, or made, in writing and sent by post to the nominated correspondence address of the Policyholder as last notified in writing to the Insurer.

## 6. Making changes to the Policy

Only the Insurer or the Policyholder can change the Policy and no other Insured Person has any legal right to enforce any part of it.

### 6.1 When the Policyholder can make changes to the Policy

The Policyholder can only make changes to the coverage provided by the Policy at the beginning of each Policy Term. Any changes made to the coverage will apply to each Insured Person covered under the Policy and an additional premium may be charged.

- If the Policyholder wants to change the cover for Prescription Drugs from Option 1 to Option 2, a new Application Form must be completed and the Insurer reserves the right to apply an Endorsement for Pre-Existing Conditions to an Insured Person's cover.

### 6.2 When the Insurer can make changes to the Policy

The Insurer may make alterations by way of an Endorsement to the Policy Terms and Conditions as it considers appropriate if:

a) it ceases to be reasonably practicable for the Insurer to comply with the Policy Terms and Conditions as a result of:-

   i) any change (introduced, enacted or proposed) in any legal, regulatory or other official requirements applicable to the Insurer, the Policy or the Policyholder;

   ii) a change in the interpretation or application of any such legal, regulatory or other official requirements; or

   iii) compliance with any request from any government, statutory or regulatory agency or authority.

b) there is any change to the basis of taxation which applies to the Insurer or to the Policy.

The Insurer can make reasonable and appropriate changes to the Policy Terms and Conditions (or issue a replacement set of Policy Terms and Conditions) at any time while the Policy is in force. The Insurer will give the Policyholder no less than thirty (30) days' notice by post of a change to these Policy Terms and Conditions and the notice of change may be included in any documentation the Insurer issues to the Policyholder.

Changes to the Policy Terms and Conditions that are outside of the Insurer's control or not to the Policyholder's detriment will take place immediately. All other changes will take effect thirty (30) days from the date of the notification of a change or such later date as may be specified.

## 7 Policy Termination by the Policyholder or Insurer

### 7.1 When the Policyholder may cancel the Policy

The Policyholder may cancel the Policy at any time by providing a written request to cancel the Policy to the Broker giving the Insurer at least thirty (30) days' notice of the intention to cancel.

If the Policyholder cancels the Policy and has paid the premium in full, the Policyholder will be entitled to receive a refund of the premium paid proportionate to the number of full months of the Policy Term remaining at the time the written request to cancel is received by the Insurer. A minimum of three months' premium will be retained by the Insurer.

### 7.2 When the Insurer may cancel the Policy

**Fraud**

The Insurer may cancel the Policy if the Policyholder or an Insured Person commits a fraud which includes doing any of the following:

- Make any untrue statements to the Insurer, the Coverholder, the Claims Administrator or any other party acting on behalf of the Insurer.
- Fail to disclose any material facts relevant to the Policy or a claim.
- Act fraudulently in any other way.

If the Insurer cancels the Policy because of fraud, the Policy will become void. If this happens, the Policyholder must immediately return all monies paid by the Insurer to an Insured Person in settlement of any claim to the Insurer. The Insurer will not return any premium to the Policyholder.

### 7.3 Termination of Coverage of an Insured Person

An Insured Person's coverage under a Policy will terminate on the Premium Due Date following:

- The date the Policy or any Benefit under the Policy terminates.
- The date of death of an Insured Person.
- The date the Policyholder cancels any or all insurance benefits under the Policy.
- The date that any premium required or due on the part of the Insured Person remains unpaid.
- The date the Insured Person enters full-time military service.
- When the Insurer determines that material misrepresentation, fraud, substantial breach in contractual duties, conditions or warranties has occurred.
- The end of the Policy month coincident with or next following the date on which the Insured Person no longer qualifies as an Insured Person for insurance under this Policy.
- The date the Insured Person reaches age 70.
- In the event of a disability an employee will continue to be covered for 12 months from the date of disability or termination of employment whichever occurs first or as agreed otherwise by underwriters at time of application.

Termination of this Policy and the insurance in respect of an Insured Person will not prejudice any claim where the Policy has been terminated in accordance with the provisions under the Claims Provisions section of this Policy. The Limitations, Exclusions and other terms and conditions of coverage applicable to this Policy will apply.

## 8. Complaints procedure

At Anahita Insurance Corporation, each of our customers is important to us, and we believe you have the right to a fair, swift and courteous service at all times. We are committed to providing you with excellent service and exceeding our customers' expectations. If for any reason you are not entirely satisfied with any aspect of our service, please let us know.

We shall work to correct matters as quickly as possible and where appropriate, take steps to prevent the problem happening again. We value our customers and your feedback can help us improve the products and services we offer.

Your complaint will be investigated by an employee of competence not involved in the subject matter of the complaint.

We aim to resolve all complaints by close of business on the business day following receipt of the complaint. If we cannot resolve the complaint within this time due to us needing to carry out more in-depth investigations, we shall:

- acknowledge your complaint in writing within five working days with either a full response or information about the progress of the matter and a contact name for future reference.
- provide you with a final response and redress (if appropriate), within four weeks of receipt of your complaint.

Please note in some circumstances, a complaint may require more in-depth investigations and therefore a longer timeline to resolve will apply. We shall aim to resolve such in-depth complaints within 8 weeks. We shall advise you if this is the case with your complaint.

**How to complain**

You can raise your concerns by writing to the Vice President at:

Anahita Insurance Corporation
2nd Floor, CGI Tower
Warrens
St Michael
BB22026
Barbados

## 9. Data protection

We will use your personal information, including information provided about your dependants, to underwrite, administer and service the policy. By taking out a policy with us, you consent us to using your personal information and sensitive personal information. We will also use your personal information for statistical data analysis, to prevent fraud and for audit purposes.

In carrying out your instructions, processing and administering your claims, we may disclose your personal information to third parties acting on our behalf. We will ensure appropriate safeguards are in place to protect your information.

If required to do so, we will pass your personal information and information about the policy to a legal or a regulatory body.

We will continue to hold information about you and the policy for a reasonable period of time after it may have ended. After this time period, we will dispose of your personal information in a responsible way to maintain your confidentiality.

# Major Medical Benefits

**Benefits**
Notwithstanding the limits stated in the separate sections of this Policy, the Overall Maximum Limit for Medical Expenses shall not exceed the lifetime maximum as stated in the Certificate of Insurance.

Please refer to the General Exclusions section for additional limitations.

We will only cover Medically Necessary expenses incurred that are over and above the applicable Provincial Government Health Care Plan which will be reimbursed at the level shown. Benefits may be subject to maximums financial and frequency limits. Please refer to the Summary of Elected Benefits in the Certificate of Insurance for your elected plan.

**Eligibility**
All Insured Persons are eligible for major medical benefits coverage.

**Hospital Benefits**
When, by reason of Injury or Sickness, an Insured Person is confined to a Hospital, the Insurer will pay the Reasonable and Customary Costs for room and board charges (semi-private or private room accommodation up to $150 CAD per day and a maximum of $5,000 per Insured Person per Policy Term) over and above the applicable Provincial Government Health Care Plan, including the costs relating to Physicians, Surgeons, nursing, operating room, prescription drugs, dressings, Diagnostic Services, medical appliances, and any other Medically Necessary cost incurred by the Hospital for Inpatient Hospital Services, Day patient Hospital Services, as well as costs incurred in an intensive care unit.

**It is recommended that the Insured Person obtains pre- authorization from the Claims Administrator.**

**Medical, Surgical and Diagnostic Services**
When by reason of Injury or Sickness, an Insured Person incurs expenses for any of the following while under the regular care and attendance of a Physician or Surgeon, the Insurer will pay the Reasonable and Customary Costs over and above the applicable Provincial Government Health Care Plan incurred for the following:

- **Paramedical Services**. The services of a professional paramedical service are covered at a maximum of $50 CAD per visit up to an overall combined maximum of $350 CAD for visits to a registered or certified massage therapist, chiropractor, physiotherapist, psychologist, registered social worker, psychiatrist, osteopath, naturopath, speech therapist, podiatrist or acupuncturist. All paramedical professionals must be on the approved list of Regulated Health Care Professionals in their Province.
- **Private Duty Nursing at Home**. The Reasonable and Customary Cost up to a maximum of $3,000 CAD per Insured Person per Policy Term for the medical services of a licensed Nurse Practitioner in the Insured Person's home when prescribed by a Physician and related directly to a medical condition for which the Insured Person has received or is receiving treatment covered under this Policy. The nurse cannot be an Immediate Family Member or currently residing with the Insured Person.
- **Ambulance Charges**. Charges up to a maximum of $5,000 CAD for licensed ground or air ambulance transportation to the nearest Hospital, or from one Hospital to another or from a Hospital to the Insured Person's residence. Air ambulance is eligible under this provision only when the emergent situation indicates that a ground ambulance cannot reach the scene easily, quickly or the terrain makes air transportation the most practical and was Medically Necessary.

**Emergency Dental Treatment for an Accidental Dental Injury**
When an accidental blow to the mouth or face results in Injury to an Insured Person, the Insurer will pay up to a maximum of $2,500 CAD per Insured Person per Policy Term for the Emergency dental treatment necessary to restore or replace permanently attached artificial teeth or sound natural teeth lost or damaged in an Accident, and for which dental treatment is initiated within thirty (30) days following an Accident and completed within the Policy Term. Detailed medical documentation from a Physician or Dentist must be provided to support an Insured Person's claim.

**Outpatient Services**
When by reason of Injury or Sickness (unless otherwise stated), an Insured Person incurs expenses for any of the following while under the regular care and attendance of a Physician, Surgeon, Physician's Assistant, or Nurse Practitioner the Insurer will pay the Reasonable and Customary Costs incurred over and above the applicable Provincial Government Health Care Plan, for the following:

- Prescription Drugs, medicine, and serums obtainable only upon a written prescription and dispensed by a pharmacist, a Physician, chemist, Surgeon, Physician's Assistant, or Nurse Practitioner to a maximum of ninety (90) days' supply within a three (3) month period.

  Biological drugs must be preapproved by the insurer.

  Prescription drugs used for the treatment of neuroses, psychoneuroses, psychopathies or psychoses, anxiety, stress, fatigue or mental or emotional diseases or disorders of any type will be considered eligible under this Policy provide this Policy includes coverage for prescription drugs.

  Dispensing fees for all drugs are limited to a maximum of $12.30 per prescription.

- Preventative vaccines and prescribed contraceptives (excluding prescribed intrauterine devices) obtainable only upon a written prescription and dispensed by a pharmacist, a Physician, chemist, Surgeon, Physician's Assistant, or Nurse Practitioner to a maximum of a ninety (90) days' supply within a three (3) month period.

- The rental (or purchase, at the option of the Insurer) of Hospital-type bed, ventilator, respirator, hearings aids or other approved Durable Medical Equipment for temporary therapeutic use and the temporary rental of a wheelchair when prescribed by a Physician, Surgeon, Physician's Assistant, or Nurse Practitioner up to a maximum of $2,500 CAD per Insured Person per Policy Term.

- Non-Durable medical supplies such as cast, splints, canes, slings, trusses, and braces for temporary therapeutic relief when prescribed by a Physician, Surgeon, Physician's Assistant, or Nurse Practitioner up to a maximum of $1,000 CAD per Insured Person per Policy Term.

- Orthopedic footwear or orthotics up to a maximum of $300 CAD per Insured Person per Policy Term.

- Prosthetics when required as a result of a surgical procedure up to a maximum of $500 CAD per Insured Person per Policy Term.

**Vision Care – optional benefit only**
If shown as covered on the Certificate of Insurance, charges for eyeglasses, contact lenses and/or eye examinations that are required for the correction of vision and are prescribed by an ophthalmologist or optometrist up to a maximum of $250 CAD per Insured Person every 24 months.

**Emergency Medical Treatment and Evacuation (whilst temporarily outside of Canada)**
If an Insured Person is temporarily outside of Canada, the Insurer will reimburse the Reasonable and Customary Costs of Medically Necessary Outpatient treatment provided by or under the care of a Physician or Surgeon that an Insured Person needs by reason of Injury or Sickness in an Emergency situation.

**If the Insured Person requires Inpatient or Day patient treatment in a Hospital, they must contact the Claims Administrator before proceeding with the treatment otherwise the claim will not be covered.**

In the event of Injury or Sickness resulting in Emergency hospitalisation, the Claims Administrator must be contacted immediately following such hospitalisation.

If it is deemed Medically Necessary to evacuate an Insured Person who has a critical medical condition as determined by the Insurer to the nearest Hospital equipped to provide appropriate care and facilities, the Insurer will reimburse the Reasonable and Customary Cost of emergency evacuation and medical care to such Hospital. The Insurer will also reimburse reasonable transportation costs for one other person accompanying the patient when this is deemed necessary, and will pay the cost of a one-way economy airfare back to Canada. If this Benefit is provided by another insurer, this Policy automatically becomes the second payor.

# Dental Care

**Benefits**

We will only cover dental expenses that are over and above the applicable Provincial Government Health Care Plan which will be then reimbursed at the level shown. Benefits may be subject to maximum financial and frequency limits. Please refer to the Summary of Elected Benefits in the Certificate of Insurance for your elected plan.

Please refer to the General Exclusions section for additional limitations.

**Eligibility**

All Insured Persons are eligible for dental care coverage.

**Basic Care - Diagnostic Services**

- One complete oral examination every five (5) years.
- Oral pathology, periodontal, surgical, prosthodontic, and endodontic examinations.
- Limited oral examinations once every nine (9) months except that only one (1) limited oral examination is covered in any year that a complete oral examination is also performed.
- Non-Emergency bite wing radiographs, once every nine (9) months.
- Limited periodontal examinations once every six (6) months.
- Specific and Emergency examinations (including bite wing and intra-oral radiographs).
- Complete series of intra-oral radiographs (non-Emergency), once every three (3) years.
- Panoramic radiographs once every five (5) years. Services provided in the same year as a complete series of intra-oral radiographs are not covered.
- Radiopaque dyes used to demonstrate lesions.
- Interpretation of radiographs or models from another source.
- Laboratory reports.

**Basic Care - Preventative Services**

- Polishing or prophylaxis once every twelve (12) months and once every nine (9) months for Dependent children only.
- Scaling and root planing – ten time units every twelve (12) months.
- Topical application of fluoride once every nine (9) months for Dependent children only.
- Pit and fissure sealant on bicuspids and permanent molars, once every five (5) years for Dependent children only.
- Space maintainers.
- Maintenance of space maintainers.
- Finishing restorations.
- Endodontic treatment – Limited to root canal therapy only.

*Please Note:* A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval.

No Benefit will be paid for:

- Custom fluoride appliances.
- Audio-visual oral hygiene instruction.
- Nutritional counselling.
- Whitening treatments.

**Basic Care - Minor Restorative Services**

- Caries, trauma, and pain control.
- Amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least three years old or the existing filling was not covered under this plan.
- Retentive pins and prefabricated posts for fillings.
- Refabricated crowns for primary teeth.
- Endodontic treatment – Limited to root canal therapy only.

**Basic Care - Oral Surgery**

- Removal of teeth.
- Surgical exposure of teeth.
- The following procedures for remodelling and recontouring oral tissues:
    - minor alveoplasty;
    - gingivoplasty and stomatoplasty;
    - surgical incisions;
- Surgical excisions of tumors, cysts and granulomas.
- Treatment of fractures, including related bone grafts to the jaw.
- Treatment of maxillofacial deformities, including related bone grafts to the jaw and cheiloplasty.

Palatal obturators, although not listed with oral surgery in the Canadian Dental Association Uniform System of Coding and List of Services, are also covered under this provision. Cleft palate obturators are not covered.

No Benefits will be paid for:

- Implantology, abutments, posts or any implant related retentive devices.
- Surgical movement of teeth.
- Services performed to remodel or recontour oral tissues, other than those listed above under **Basic Care: Oral Surgery**; or alveoplasty or gingivoplasty performed in conjunction with extractions.

**Basic Care - Adjunctive Services**

- Minor remedies for relief of dental pain when provided on an Emergency basis.
- Therapeutic injections.
- Anaesthesia required in relation to covered services. The provision of general anesthetic facilities, equipment and supplies is covered only when a separate anaesthetist is required.

No Benefits will be paid for hypnosis or acupuncture.

**Major Services**

Crowns and onlays are covered when a tooth has extensive structural loss or a fracture than cannot be adequately restored using other procedures. The following crowns and related items are covered:

- Metal, plastic, porcelain, and ceramic crowns. Coverage for crowns on molars is limited to the cost of metal crowns. Coverage for complicated crowns is limited to the cost of standard crowns.
- Onlays. Coverage for tooth-coloured onlays on molars is limited to the cost of metal onlays.
- Posts, cores, and pins related to covered crowns.
- Copings related to covered crowns.
- Repairs to covered tooth-colored materials.
- Removal and recementation of crowns and onlays.

Replacement crowns and onlays are covered when the existing restoration is at least five years old and cannot be made serviceable.

No benefits will be paid for:

- Veneers.
- Recontouring existing crowns.
- Staining porcelain.
- Inlays, except as provided under alternative benefits.

If a crown or onlay is provided when a tooth could have been adequately restored using other procedures, alternative benefits will be provided based on coverage for fillings.

Dentures and bridgework, including overdentures are covered when required to replace one or more teeth extracted while the person was insured for major coverage.

**Orthodontic Services - optional benefit only**

Benefit is only payable if selected at the time of application and is subject to a nine (9) month waiting period.

- Treatment of malocclusion for Dependent children under the age of 19 years only.

**Dental Care exclusions and limitations**

The following expenses are not eligible for reimbursement under this Policy:

- Expenses that private insurers are not permitted to cover by law.
- Services or supplies the Insured Person is entitled to without charge by law or for which a charge is made only because the Insured Person has insurance coverage.
- Services or supplies that do not represent reasonable treatment.
- Services or suppliers associated with:
    - treatment performed for cosmetic purposes.
    - congenital defects or developmental malformations in people 19 years of age or over.
    - temporomandibular joint disorders.
    - myofacial pain.
    - implants.
- Persons age 70 or over.
- Any dental expense incurred while covered under the Policy but submitted more than 90 days following the date the expense was incurred, more than 90 days after the Insured Person's coverage has been terminated or more than 90 days after the Policy has been terminated, whichever is earlier.

## Accidental death & dismemberment (AD&D) – optional benefit only

**Benefits**
If shown as covered on the Certificate of Insurance, please refer to the Certificate of Insurance for confirmation of the Principal Sum that applies.

**Eligibility**
The Primary Insured Person and their Dependents, as defined by this policy, who have paid the required premium or had such premium paid on their behalf by the policyholder. Spousal amounts cannot exceed that of the primary insured and the maximum issue amount for a dependent child cannot exceed $50,000.

**Aggregate Limit of Liability: $10,000,000 CAD**
The Insurer shall not be liable for any amount in excess of the above stated aggregate limit of liability.

If the aggregate amount of all indemnities otherwise payable by reason of coverage provided under this Policy exceeds such aggregate limit of liability, the Insurer shall not be liable as respects to each Insured Person for a greater proportion of the indemnity otherwise payable than the aggregate limit of liability bears to the aggregate amount of all such indemnities.

**Coverage**
Accidental death, dismemberment, loss of sight, hearing or speech, and paralysis.

If such injuries shall result in any one of the following specific losses within one year from the date of Accident, the Insurer will pay the Benefit specified as applicable thereto, based upon the Principal Sum stated on the Certificate of Insurance. However not more than one (the largest) of such Benefits shall be paid with respect to all injuries resulting from one Accident.

| | |
|---|---|
| Loss of life | The Principal Sum |
| Total loss of both hands or both feet | The Principal Sum |
| Total loss of entire sight of both eyes | The Principal Sum |
| Total loss of one hand and one foot | The Principal Sum |
| Total loss of one hand and entire sight of one eye | The Principal Sum |
| Total loss of one foot and entire sight of one eye | The Principal Sum |
| Total loss of speech and hearing in both ears | The Principal Sum |
| Loss of use of both arms or both hands | The Principal Sum |
| Paralysis | The Principal Sum |
| Total loss of one arm or one leg | Three quarters of The Principal Sum |
| Loss of use of one arm or one leg | Three quarters of The Principal Sum |
| Total loss of one hand or one foot | Two-thirds of The Principal Sum |
| Loss of entire sight of one eye | Two-thirds of The Principal Sum |
| Loss of use of one hand | Two-thirds of The Principal Sum |
| Total loss of speech or hearing | Two-thirds of The Principal Sum |
| Total loss of thumb and index finger of the same hand | One-third of The Principal Sum |
| Total loss of four fingers of the same hand | One-third of The Principal Sum |
| Total loss of hearing in one ear | One-quarter of The Principal Sum |
| Total loss of all toes of the same foot | One-eighth of The Principal Sum |

'Total loss' shall mean:

- With respect to hand or foot, the actual severance through or above the wrist or ankle joint;
- With respect to arm or leg, the actual severance through or above the elbow or knee joint;
- With respect to eye, the total and irrecoverable loss of sight;
- With respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree;
- With respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device;
- With respect to thumb and index finger, the actual severance through or above the first phalange;

- With respect to fingers, the actual severance through or above the first phalange of all four fingers of the same hand;
- With regard to toes, the actual severance of both phalanges of all toes of the same foot.
'Paralysis' shall mean the complete and irrecoverable paralysis of limbs as a consequence of:
- quadriplegia (paralysis of both upper and lower limbs);
- paraplegia (paralysis of both lower limbs); or
- hemiplegia (total paralysis of upper and lower limbs of one side of the body).

'Loss of use' shall mean the total and irrecoverable loss of function of an arm, hand or leg, provided such loss of function is continuous for twelve consecutive months and such loss of function is thereafter determined on evidence satisfactory to the Insurer to be permanent.

**Exposure and Disappearance**
Loss resulting from unavoidable exposure to the elements and arising out of hazards described above shall be covered to the extent of the Benefits afforded to the Policyholder.

If the body of the Policyholder has not been found within one year of the disappearance, stranding, sinking or wrecking of the conveyance on which the Policyholder was travelling at the time of the Accident, it shall be presumed, subject to all other policy conditions, the Policyholder suffered loss of life resulting from bodily Injury sustained in the Accident and covered under this policy.

**Please also refer to the Policy Exclusions section for exclusions and limitations.**

## General exclusions

This Policy does not cover expenses directly or indirectly caused by:

- Pre-Existing conditions
- Injury or Sickness caused by an act of declared or undeclared war; Terrorism, service in the military forces of any country, including non-military units supporting such forces; the Insured Person committing or attempting to commit civil tort, an indictable offence or a criminal act, taking part in a riot (meaning the Insured Person is taking an active part in common with three or more others by using or threatening to use force or violence without authority of law).
- Air travel, other than as a passenger in a certified commercial aircraft that provides passenger service and complies with government regulations concerning pilot licensing and current certificates of airworthiness.
- Radioactive Contamination: This Policy excludes any claim directly or indirectly consequent upon or contributed by:
  a) ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel; or
  b) radioactive toxic explosion or other hazardous properties of any explosion, nuclear assembly, or nuclear component thereof, howsoever such release or explosion is caused.
- Any claim as a result of venereal disease or Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immuno Deficiency Virus (HIV) howsoever these have been acquired or may be named, unless specifically stated otherwise in this Policy.
- Injury or Sickness caused by deliberate exposure to exceptional danger (except in an attempt to save human life).
- Injury or Sickness caused by the Insured Person being under the influence of alcohol or drugs.
- Misuse of medication, use of intoxicants or illegal drugs, or treatment thereof or Accidents related thereto;
- Neuroses, psychoneuroses, psychopathies or psychoses, anxiety, stress, fatigue or mental or emotional diseases or disorders of any type except as specifically stated otherwise in this Policy. Prescription drugs used for the treatment of such conditions will be considered eligible under this Policy provided this Policy includes coverage for prescription drugs.
- Prescription medications required in the treatment or control of a Chronic Condition within the first 24 months of the Insured Person's Effective Date of coverage, unless coverage has been granted under the Grandfathering provisions of this Policy (*see section 2 of this Policy for an explanation of this term)*.
- Prescription medications or lifestyle drugs prescribed for the treatment of hair loss, obesity / weight loss, erectile dysfunction or smoking cessation.
- Services primarily for weight reduction or treatment of obesity including morbid obesity, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity surgery, even if the Insured Person has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction.
- Injury or Sickness caused by the Insured Person's active participation in acts of Terrorism (as defined in this Policy).
- Actual or threatened malicious use of Biological Agents or Chemical Agents.
- Suicide or attempted suicide or intentional self-injury or through being in a state of insanity

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- Biological drugs unless approved in advance by the Insurer.
- Expenses associated with pregnancy and childbirth, including the care and treatment of a newborn child while in Hospital immediately following birth and the subsequent medical program recommended for the newborn child including checkups and immunizations.
- Examinations by, or the services of, a Physician if required solely for the use of a third party.
- Elective and/or cosmetic surgery, whether or not for psychological reasons unless required as the result of Injury incurred while this Policy is in force and pre-approved by the Insurer.
- Any costs incurred during any period for which the appropriate premium has not been paid or while the Policy is not in force as to the Insured Person.
- Any Medical Expense incurred while covered under this Policy but submitted more than ninety (90) days following the date the expense was incurred or more than ninety (90) days after coverage terminated.
- Fertility or infertility treatment and / or drugs related thereto.
- Termination of pregnancy or expenses relating thereto.
- Treatment received outside of Canada when the Insured Person has travelled against medical advice.
- Treatment received outside of Canada when the Insured Person has travelled for the purpose of receiving treatment or whilst knowing that medical treatment was required.
- Hazardous exclusion: The Insurer shall not be liable for any loss to the Insured Person(s) resulting directly or indirectly from any one or more of the following activities, or caused by, contributed by or occasioned by, or happening through, arising from, or in consequence of any Accident or Injury occurring whilst the Insured Person is engaged in any hazardous activity, pastime or pursuit including, but not limited to, hunting, big-game-hunting, safari, paint-balling, roller-blading, skateboarding, caving, mountaineering or rock climbing normally requiring the use of ropes or guides, potholing or underground activity, skydiving, parachuting, paragliding, bungee-jumping, ballooning, hang-gliding, delta-plane flying, underwater activities that require the use of artificial breathing apparatus, scuba-diving, water-sports, canyon water-sport, kayaking, sailing or yachting outside coastal waters or from country to country, deep sea fishing, jet-boating, white water rafting, fencing, martial arts, rallying, racing of any kind other than on foot, and undertaking any professional or semi-professionally sponsored organized sport (including any incidents involving saddle-bearing animals):

## General information, provisions and limitations

**Adverse Consequences**
The Insurer reserves the right to refuse to settle a claim where to do so would, in its reasonable opinion, result or be likely to result in either the Insurer or the Policyholder suffering material adverse financial, regulatory or tax consequences.

**Arbitration**
Any differences with respect to medical opinion will be settled between two medical experts appointed by the Insurer and the Policyholder. This dispute resolution will be in writing. Any differences of opinion between the two medical experts shall be referred to an umpire who shall have been appointed in writing at the outset by the two medical experts.

**Conformity with Provincial Statutes**
Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the province in which this Policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such province.

**Designation or change of beneficiary**
Subject to any statutory restrictions, a Policyholder may designate a beneficiary to receive death benefits payable under this Policy or may change any beneficiary already appointed by filing written notice. No designation, change of beneficiary or assignment of interest under the policy shall be binding upon the Insurer until the original or a duplicate thereof is received by the Insurer. The Insurer assumes no responsibility for the validity or legal sufficiency of such designation or change of beneficiary assignment.

**Entire Contract - Changes**
This Policy, the application of the Policyholder and (if required by the Insurer) the individual applications of the Insured Persons constitute the entire contract between the parties, and any statement made by the Policyholder or by any such person shall, in the absence of fraud and unless expressly stated to the contrary, be deemed a representation and not a warranty. No such statement shall void the insurance or reduce the benefits under this Policy or be used in defence to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Policyholder, except a fraudulent misstatement, be used at all to void this Policy after it has been in force for two years from the date of its issue, nor shall any such statement of any person eligible for coverage under the Policy, except a fraudulent misstatement, be used at all in defence to a claim for loss incurred after the insurance coverage with respect to which claim is made has been in effect for two years from the date it became effective.

No change in this Policy shall be valid unless approved by an executive officer of the Insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

**Force Majeure**
No liability on the part of the Insurer shall arise if the Insurer is prevented from fulfilling its obligations under the Policy by reason of any supervening event beyond its reasonable control (including, without limit, any act of god, war, national emergency, Terrorism, fire, flood, strike or industrial action).

**Governing Law**
This Policy is governed by the Laws of Barbados and any dispute arising out of this policy shall be settled in the courts of Barbados.

**Invalidity**
If any provision of this Policy is found by any court or administrative body of competent jurisdiction to be invalid or unenforceable, such invalidity or unenforceability will not affect the other provision of this Policy which will remain in full force and effect.

**Legal Actions**
No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written Proof of Loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years (or the minimum time, if more than three (3) years, permitted by law in the jurisdiction where the Insured Person resides) after the time written Proof of Loss is required to be furnished.

**Legal Discharge**
Payment of Benefits by the Insurer to an Insured Person or beneficiary thereof, shall be treated as being made in legal discharge of all obligations owed by the Insured to the Policyholder in respect of such Insured Person or beneficiary under this Policy and for this purpose, payments to a Insured Person or beneficiary thereof shall be considered as payments to the Policyholder.

**Misrepresentation and Fraud**
All Benefits under this Policy shall be voidable if the Insurer determines, whether before or after the loss, that the Insured Person has concealed or misrepresented any material fact or circumstance concerning this Policy or his/her interest therein, or in the case of fraud or false swearing by You or if You refuse to disclose information or permit the use of such information, pertaining to any of the Insured Persons under this Policy. The completed and signed Application Form is the basis of and forms part of this Policy and any erroneous responses therefore constitute material misrepresentation. Any claim to which any concealed or misrepresented material fact or circumstance pertain shall not be payable under this Policy and You shall be solely responsible for all expenses relating to Your claim, including Emergency medical evacuation costs.

**Other insurance**
If, at the time of loss, the Insured Person has insurance from another source for Benefits provided under this Policy, the Policy with the earliest Effective Date will be deemed to be first payor. Any Benefits payable by the following shall not be considered as a covered cost under this Policy:

- Any group or individual Hospital or medical plan.
- Any government Hospital or medical plan.
- Any Worker's Compensation Act.
- Any public or tax-supported agency

**Payment of Benefits**
The Claims Administrator will, on behalf of the Insurer, make payment to the Policyholder or legal representative or directly to the provider of treatment or services.

Benefit for accidental loss of life will be payable to the beneficiary of record in a lump sum. If, at the death of the Policyholder, there is no surviving beneficiary, payment will be made in one sum to the estate of the Policyholder.

Payment will be in Canadian currency.

**Physical examinations and autopsy**
The Insurer, at its own expense, shall have the right and opportunity to examine the body of any Insured Person whose Injury is the basis of a claim as it may reasonably require during the pendency of a claim hereunder and to request an autopsy in case of death where it is not forbidden by law.

**Pre-Authorisation**
Medical treatment must be pre-authorised by the Insurer or the Claims Administrator on behalf of the Insurer and the Insurer's decision whether or not to proceed / pay Benefits is final.

**Sanction Limitation and Exclusion Clause**
No (re)insurer shall be deemed to provide cover and no (re)insurer shall be liable to pay any claim or provide any Benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such Benefit would expose that (re)insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

**Subrogation**

If an Insured Person suffers a loss covered under this Policy, the Insurer is granted the right from the Insured Person to take action to enforce all the rights, powers, privileges and remedies of the Insured Person, to the extent of Benefits paid under this Policy, against any person or organisation which caused such loss. Additionally, if no fault Benefits or other collateral sources of payment of expenses are available to the Insured Person, regardless of fault, the Insurer is granted the right to make a demand for and recover those Benefits. If the Insurer institutes an action, the Insurer may do so at its own expense, in the Insured Person's name, and the Insured Person will attend at the place of loss to assist in the action. If the Insured Person institutes a demand or action for a covered loss he or she shall immediately notify the Insurer so that it may safeguard its rights. The Insured Person shall take no action after a loss that will impair the rights of the Insurer.

**Statutory Conditions**

The Application Form, the Policy, any document attached to the Policy when issued, and any amendment to the contract agreed upon in writing after the Policy is issued, constitute the entire contract between the Insurer and the Policyholder. Any provision of the Policy which, on its Effective Date, is in conflict with the statutes of the jurisdiction in which the Policy was issued is hereby amended to conform to the minimum requirements of such statutes.

**Workers' Compensation Laws**

This policy is not in lieu of, and does not affect, any requirements for coverage under any Workers' Compensation Law.

**Schedule A – Durable Medical Equipment**

The Durable Medical Equipment listed below are covered when prescribed by a Physician, Surgeon, Physician's Assistant or a Nurse Practitioner and include, but is not limited to:

1. The rental or purchase of a hospital-type bed, ventilator, respirator or other approved durable equipment for temporary therapeutic use.
2. Hearing aids
3. Cost of an iron lung or other approved durable equipment for temporary therapeutic use.
4. The following diabetic supplies:
    - Insulin syringes.
    - Test strips.
    - Bloodletting devices, including platforms and lancets.
    - Blood-glucose monitoring machines, once every four Policy Terms, per Insured Person.
    - Insulin infusion sets, not including infusion pumps.
    - External insulin infusion pumps when recommended by an endocrinologist or when required for pregnant diabetics, once every five Policy Terms. The maximum amount payable is $2,000 per Insured Person for each pump.
    - Needle-less insulin jet injectors, once in an Insured Person's lifetime. The maximum amount payable is $1,000.
5. The following communication aids:
    - Laryngeal speaking aids, when no alternative method of communication is possible. The maximum amount payable is $1,000 in an Insured Person's lifetime.
6. The following breathing equipment:
    - Oxygen and the equipment needed for its administration.
    - Intermittent positive pressure breathing machines.
    - Continuous positive airway pressure machines.
    - Apnoea monitors to a maximum of $2,000.
    - Mist tents and nebulizers.
7. The following mobility aids:
    - Canes, walkers, crutches, and parapodiums.
    - Rechargeable batteries for covered wheelchairs.
    - The temporary rental of a wheelchair (or purchase, at the option of the Insurer, based on financial exposure). Special wheelchairs necessary to permit independent participation in daily living are included. Special wheelchair features required primarily for participation in sports are not covered.
8. The following medical supplies.
    - Colostomy and ileostomy supplies.
    - Catheters and catheterization supplies.
    - Tube feeding pumps and pump sets.
    - Transcutaneous nerve stimulators for the control of chronic pain. The maximum amount payable is $700 in an Insured Person's lifetime.
    - Custom-made pressure supports for lymphedema;
    - Extremity pumps for lymphedema or severe post-phlebitic syndrome, once in an Insured Person's lifetime. The maximum amount payable is $1,500.
    - Custom-made graduated compression hose, to a maximum of four pairs per Insured Person, per Policy Term.
    - Custom-made burn garments.