Employee Benefits Booklet

Used Car Dealers Association
UCDA
MEMBERS ONLY HEALTH PLAN

Group Health and Dental Insurance Plan
Exclusively for Members of
The Used Car Dealers Association of Ontario

THE CAPITAL GROUP
Insurance Inc.
Employee Benefits Specialists Since 1969

www.UCDAbenefits.com

The Used Car Dealers Association of Ontario has worked together with your plan sponsor to develop a package of benefits to meet your needs. These benefits are an important part of your financial security provided by your plan sponsor.

Questions regarding what's covered?
If you have any questions about your benefits, you can ask your plan sponsor, or call **NexgenRx** on our toll-free at line 1-866-424-0257.

Adding optional benefits
Should you wish to add optional benefits such as life insurance, critical illness protection, or personal disability income insurance, please contact **The Capital Group Insurance** at 1-866-476-8722. You can also visit our website at UCDABENEFITS.COM

To purchase Top-Up Travel coverage, (over 60 days) call:
Canada/USA, toll free 1-877-832-6025
Collect 1-819-566-2066

Downloading Claim and Enrolment Forms
www.UCDAbenefits.com/forms.html

How to make claims:

Prescription Drugs: Use pay-direct drug card from NexgenRx
Dental Care: Electronic dental claim submission
Extended Health: Mail ORIGINAL copies of receipts
(Include claim form from UCDAbenefits.com/forms.html)
Travel Insurance: call emergency number on back of your UCDA member ID card or refer to page 18 for contact info
Mail your claim to: **NexgenRx Inc.**

145 The West Mall
P.O. Box 110U
Toronto,ON. M8Z 5M4

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Definitions

Here are definitions for some of the terms in this booklet. You will find more definitions included in each section.

Co-Insurance

Co-insurance is the rate at which benefits are payable.

Child

A child is your unmarried son or daughter. This includes a step-child, foster child and a common-law child. Common-law child means a child of your common-law spouse and another person. This child must be dependent on you and your common-law spouse for support and maintenance. A child must be under age 19, and dependent on you for support and maintenance.

Coverage is continued while the child is under age 25 and attending an accredited college or university on a full-time basis. Upon request you must provide confirmation that the child is a full-time student and remains dependent on you for support and maintenance.

Coverage is continued beyond the maximum ages indicated above for a child who is physically or mentally handicapped as long as the child became handicapped before reaching the applicable maximum age stated above, and you provide proof satisfactory to us that the child is not capable of self-support due to the handicap.

Dependent

A dependent is your spouse or child. Anyone who is in the armed forces full-time is not eligible to be a dependent.

Emergency

An emergency means any sudden, unexpected illness or injury for which the insured person needs immediate treatment.

Family

A family is you and all your dependents that are covered under the contract.

Covered Person

Covered person means you or any one of your dependents who is covered under the contract.

Spouse

A spouse is a person to whom you are legally married or with whom you have a common-law spouse relationship. Common-law spouse means a partner of the opposite sex whom you have lived with for at least 12 months or, where applicable by law, the same sex, who has lived with you for at least 12 months.

Alternatively, an ex-spouse for whom you are legally liable to provide benefits, may be considered eligible under this plan. The maximum number of spouses that can be covered at one time is 1.

General Terms

Waiting Period For Coverage

You are eligible the day after the waiting period for coverage ends. The waiting period for coverage begins on the date you start employment and ends on the date you complete 3 months of employment for Drug and Extended Health coverage. You will be eligible for Dental coverage after an additional 3 month waiting period, unless proof of prior coverage has been provided.

Confirming Your Coverage

When your coverage begins, you will receive a NexgenRx Benefit Card outlining your coverage. Upon receipt, please check the card to make sure the information is correct.

What Changes To Report To Your plan administrator?

You must report the following changes immediately to your employer:

- changes in dependent coverage, including the birth of a child ;
- change of spouse;
- change of name;
- change of banking information (if NexgenRx is depositing your claim expenses directly into your bank account).

You report these changes by:

- Advising your plan administrator of any changes in your coverage needs such as a change from single to family status

When Your Coverage Ends

On the earliest of the following dates:

- When you reach age 70 for drug coverage and age 79 for dental and extended healthcare (including travel insurance)
- The date your employment or membership with the plan sponsor ends
- The date this contract terminates

A dependent's coverage will end on the earliest of the following dates:

- The date your coverage ends
- The date you request termination of dependent coverage
- The date your dependent no longer satisfies the definition of dependent

Legal Action

No legal action may be taken until 60 days after proof of claim is given to NexgenRx or more than one year after the deadline for providing proof of claim. If you have received benefit payments but the payments end, no legal action may be taken more than one year after the last payment was made.

Submitting Claims

Co-ordination Of Benefits With Your Spouse's Plan

Co-ordination with your spouse's plan is one of the advantages of group coverage. It may allow you to receive up to 100% of costs. First, you must have family coverage that includes Health Care coverage and have an eligible spouse and/or children. Second, your spouse must have the same type of coverage where he/she works.

Claiming Your Spouse's Expenses

If you are claiming your spouse's expenses, a claim must be sent to your spouse's plan first. Your spouse's plan will pay for the portion of the claim that is covered by them and send your spouse an explanation of payment. You can then send a copy of the explanation and a copy of the receipts, along with a claim for the unpaid portion, to NexgenRx.

Claiming Your Child's Expenses

If you are claiming expenses for your child, you must first claim from the plan of the parent with the earliest birthday (month and day) in the calendar year. For example, if your birthday is May 19th and your spouse's birthday is June 11th, your child will claim under your plan first. Then, the claim for the unpaid portion should be sent to your spouse's plan along with a copy of the explanation of payment and a copy of the receipts.

If you are separated or divorced, claims for your child's benefit must be co-ordinated based on the standard industry guidelines.

Claiming Your Expenses

If you are claiming your expenses, the claim must be sent to NexgenRx first. NexgenRx will pay for the portion of the claim that is covered by your plan and send you an explanation of payment. Your spouse can then send a copy of the explanation and a copy of the receipts, along with a claim for the unpaid portion, to his/her group carrier.

How to submit a claim

Complete the claim form that is available online at www.ucdabenefits.com/forms.html

Make sure that your receipts include:

- the name of the person who received the service or supply
- the date the service or supply was received
- the type of service or supply and
- the cost

Mail your claim to: NexgenRx Inc.
145 The West Mall
P.O. Box 110U
Toronto,ON. M8Z 5M4

Your Health Care Coverage

Your plan will pay for the usual cost of covered services and supplies that are medically necessary to treat an illness, injury or pregnancy.

It will cover:

- The amount that is usually charged for the service or supplies in the area in which the charge is made.
- Services and supplies that are needed to diagnose or treat an illness, injury or pregnancy and that are recognized by the Canadian Medical Association as effective and appropriate and based on accepted standards of Canadian health care.
- Services and supplies that private plans are legally allowed by the government to cover. The plan will not cover services or supplies that are covered by the government plan in your home province.
- Charges for services and supplies that are incurred while the person is covered under this plan

Your coverage includes the following:

- Pay Direct Drugs
- Hospital accommodation
- Eye examinations
- Medical services and equipment
- Paramedical services
- Referrals for medical treatment outside the insured person's home province
- Emergency out of province/country treatment
- Travel assistance
- Dental Expenses

What Is Covered and How Much the Plan Will Pay

Drugs

Covered expenses under the drug plan include both the ingredient cost and the dispensing fee. The plan covers up to $5 of the dispensing fee. Pharmacies charge varying levels of dispensing fees and it is in your own best interest to find a pharmacy that will accept this amount as full payment.

The plan has no deductible.

Your benefit year is December 1 to November 30 each year.

The plan pays up to 80% for eligible expenses.

The plan has an annual maximum of $1 million per person.

If a generic drug can be substituted for a brand name drug, the plan will only cover the cost of the generic substitute with the lowest price.

However, if the prescription states 'no substitute,' the plan will cover the cost of the brand name drug.

Your plan pays for most drugs that legally require a written prescription as well as prescribed over- the- counter (OTC) drugs and supplies considered to be life sustaining. Examples of these OTC items include insulin, diabetic test strips, disposable insulin needles and syringes, oral potassium supplements, Epi-Pen, nitroglycerin low dose aspirin for blood thinning, niacin for cholesterol lowering, vitamin B12 for certain types of anaemia .

The plan covers up to a 34 day supply of therapeutic drugs, and up to a 100 day supply for maintenance drugs.

You and your dependants can use the NexgenRx drug card to purchase eligible drugs. Use of the NexgenRx drug card authorizes NexgenRx or their authorized agent, to inform pharmacists and physicians on patient safety issues for you and your dependents. NexgenRx, or our authorized agent, is not legally liable for this information.

You and your dependants may not be able to use the NexgenRx drug card to buy drugs from a physician, dentist, clinic, hospital, or some pharmacies, but you can make a claim for the cost of eligible medicines by using a claim form and attaching the receipts. A receipt must show the prescription number and the name of the drug or Drug Identification Number (DIN).

If your NexgenRx drug card is lost or stolen, it must be reported immediately to your administrator.

You and your dependants CANNOT use the drug card to purchase the following items:
Check for coverage for these items under your Extended Health Care Plan. You may be able to claim them, but must use a paper claim form.

- alcohol swabs
- appliances
- atomizers
- certain equipment
- ostomy supplies
- devices for giving inhaled medications (for example, an aero chamber) blood glucose monitor and prosthetic devices

We will NOT pay for the following:

- hair growth stimulants
- fertility drugs
- erectile dysfunction drugs
- immunizations and vaccines
- anti-obesity drugs
- alcohol
- bandages
- contraceptives other than birth control pills
- cosmetic items
- sunscreens
- cotton
- vitamins (except injectables), minerals, dietary supplements food substitutes, infant food or formula
- disinfectants
- homeopathic medicines
- non-disposable insulin injectors
- products which can be bought without a prescription, other than some life supporting products
- spring loaded devices used to hold lancets

Extended Health Care (EHC) benefits

For your extended health care benefits:

The plan has no deductible.

Your benefit year is December 1 to November 30 each year.

The plan pays up to 80% of eligible expenses.

The plan has an annual maximum of $35,000/person and up to $140,000/family.

The plan will cover Class "A" Driver's medicals as required by the Ontario Ministry of Transportation up to $100 every 36 months.

Hospital Accommodation

For hospital services there is no deductible and the plan pays at the rate of 100% for eligible expenses.

For in-hospital services the plan will cover the difference between the cost of a ward and a semi-private room in a hospital, up to $250/person/day for up to 40 days/year.

The hospital stay must be because of illness, injury or pregnancy and the patient must be confined on an in -patient basis.

Vision Care

For vision care there is no deductible and pays at the rate of 100% up to $200 every 24 months.

The plan will cover up to $50 for eye exams every 24 months (included in the $200 overall maximum.

Paramedical Practitioner Services

The plan will pay reasonable and customary fees to the maximums listed below.

The plan will pay an overall annual maximum of $500/practitioner/person and up to $1,200/practitioner/family.

The plan will pay for the following practitioners:

Chiropractors ($30 per visit)

Osteopaths ($30 per visit)
Podiatrists ($30 per visit)
Acupuncturists ($30 per visit)
Naturopaths ($50 per visit)
Physiotherapists ($50 per visit)
Speech Therapists ($30 per visit)
Occupational Therapists ($30 per visit)
Psychologists ($50 per visit)
Audiologists ($30 per visit)
Nutritionists ($30 per visit)
Registered Massage Therapy ($30 per visit)

These practitioners must be registered in the province where the service is given, be performing a service for which their registration applies and cannot be a person who normally lives with you nor be a person related to nor a member of your immediate family.

The plan will cover the cost of up to 1 laboratory test or x-ray recommended by a licensed chiropractor, osteopath, chiropodist or podiatrist in any benefit year.

Registered Nurses

The plan will cover these services to a maximum of $10,000/person/year and up to $40,000/family/year.

Services provided by a Registered Nurse, Registered Nursing Assistant or Registered Practical Nurse, must be approved by NexgenRx in advance. These services must be provided in the insured person's home by a Registered Nurse, Registered Nursing Assistant or Registered Practical Nurse who does not normally live with, is not related to, nor is a member of the insured person's immediate family.

The plan will not cover the cost of a Registered Nurse, Registered Nursing Assistant or Registered Practical Nurse if the care they provide is not the skilled duties that only they can provide. We will also not cover the cost of care from a Registered Nurse, Registered Nursing Assistant, or Registered Practical Nurse that is provided in a nursing home, rest home, home for the aged, hospital, or any facility that provides similar care.

Ambulance Services

The plan will cover the cost of a licensed ambulance or other emergency service, that transports the insured person to and from the nearest hospital that is able to give the necessary treatment up to a maximum of $100/person/trip. This also covers travel between hospitals.

Convalescent Care

The plan will pay for active treatment or convalescent care in a Rehabilitative, Convalescent or Chronic Care Institute when prescribed by a physician, up to $150 per day for semi-private accommodation to a maximum of 30 days per year.

After age 65, the lifetime maximum is $6,000/person

Home Care Services are covered up to $2,500/person/year and up to $8,000/family/year

Medical Equipment

The plan covers the cost of out-patient supplies obtained from a hospital or surgical supply company in your home province. It will also cover the cost of rental charges for wheelchairs, hospital beds and other temporary therapeutic equipment that NexgenRx approve. It may cover the cost of purchasing this equipment if NexgenRx determine that it is more economical than renting. NexgenRx must approve the purchase before it is made. The plan will pay a reasonable and customary fee for the least expensive device that is medically adequate.

The following is a list of examples of items that the plan will cover if prescribed by a physician and approved by NexgenRx:

- Aero chambers
- Apnea monitor
- Blood glucose monitor
- Breast prostheses after a mastectomy , including replacement(s) every 2 years, and 2 surgical bras in a calendar year
- Casts
- Compressors

- Crutches and canes
- Grab bars
- Hearing aids and repairs (not including batteries) up to a maximum of $500/person/5 years
- Nebulizers to administer asthma medication
- Ostomy supplies
- Oxygen and oxygen equipment
- Prosthetic lens prescribed after cataract surgery
- Surgical stockings are covered up to 2 pairs/person/year
- T.E.N.S. machine (for chronic pain)
- Walkers , braces, artificial limbs and eyes and other approved prosthetic devices
- Wigs following chemotherapy or radiation up to $200 per lifetime

The following is a list of examples of items that are not covered even if prescribed by a physician:
- Air conditioners or purifiers
- Blood pressure kits
- Breast pumps
- Craftmatic, Ultramatic or other lifestyle beds
- Exercise equipment, machines or programs
- Home or car modifications (for example, ramps or lifts)
- Humidifiers
- Mattresses (except for standard mattresses with approved hospital beds)
- Obus Formes or orthopaedic pillows.

Dental Accident
If healthy, natural teeth are damaged or lost due to a sudden impact, the plan will cover the cost of the dental services required to repair or replace the teeth if the impact that caused the damage or loss happened while you or your dependant are covered under this provision up to a maximum of $2,500/person/year and up to $10,000/family/year.

This does not include damage or loss caused by objects or food placed in the mouth.

The amount payable will pay is based on the least expensive treatment that is adequate to correct the damage. No more than the fee stated in the current Dental Association General Practitioner's Fee Guide will be covered. This treatment must be completed within 12 months of the impact. If treatment is scheduled to occur more than 90 days after the impact, NexgenRx must be given a treatment plan before the end of the 90-day period.

Orthodontic care must be for relocating teeth that are accidentally forced out of position or for splinting damaged teeth for stability. Dental procedures to correct existing cross bites, alignment of rotated teeth, closing of spaces, and uprighting teeth are not covered. Implants and treatment related to implants are also not covered.

Emergency Out-Of-Province/Country Travel Coverage
Referral for medical treatment Out of Province/Country
Please refer to the explanation of travel benefits on page 14.

What You Are Not Covered For
The plan will NOT pay for the cost of:
- health care services or supplies that you or your dependants are eligible to claim under Workers' Compensation legislation in your province of residence
- health care services or supplies required due to intentionally self-inflicted injury
- health care services or supplies required as the result of war, rebellion, or hostilities of any kind, whether or not the you or your dependant is a participant
- health care services or supplies required as the result of participation in a riot or civil disturbance
- health care services or supplies due to committing a criminal offence or provoking an assault
- services required by a court, your employer, a school or anyone other than your physician. (For example, your employer requiring a doctor's note or a court requiring that you receive psychological services.)
- treatment on temporomandibular joint (the hinge joint of the jaw)
- any service and supplies for which the you or your dependant would not normally be charged
- cosmetic treatments
- "in vitro" or "in vivo" procedures, or any other infertility procedures, unless otherwise specifically covered in this contract.
- The prescription drugs “XYREM” and “STELARA”.

- any service that we are legally prohibited from paying.

Your Dental Coverage

When Your Dental Treatment Will Cost More Than $600
If the cost of any dental treatment will be more than $600, NexgenRx recommend that you submit a "pre-determination" before the treatment is started. A pre-determination is a report describing the proposed treatment and cost. NexgenRx will determine how much of the treatment is covered before the treatment begins and give you and your dentist a written estimate of how much you will be responsible to pay before the treatment begins.

If you do not submit a pre-determination prior to the treatment being performed and submit the claim post treatment, your claim may be delayed in processing. In order to assess whether the treatment will be allowed, NexgenRx may need to obtain x-rays and or study models from your dentist. This process will delay your claim assessment.

What Is Covered and How Much the Plan Will Pay

The plan has no deductible

Your benefit year is December 1 to November 30 each year

The amount payable is a percentage (as outlined below) of the current Dental Association Suggested Schedule of Fees for General Practitioners of the province in which you reside.

The plan has an annual maximum of $1,500/person/year

Diagnostic Coverage
80% of diagnostic covered costs such as oral exams and x-rays.

Preventive Coverage
80% of Preventive covered costs such as scaling and polishing

Basic Restorative Coverage
80% of restorative covered costs such as fillings

Endodontic Coverage
80% of endodontic covered costs such as root canal therapy

Periodontic Coverage
80% of periodontic covered costs such as treatment of the gums

Basic Surgical Coverage
80% of surgical covered costs such as tooth extractions

Your maximum applies to diagnostic services, preventative services, basic restorative services, endodontic services, periodontic services and basic surgical services.

Coverage is based on the cost of the least expensive treatment that could be used to treat or prevent the dental problem. If the cost of the dental work given is more than the cost of the least expensive treatment, the plan will only cover the cost of the least expensive treatment.

Limitations

Fluoride treatments are limited to once every 12 months.
Recall exams and polishing are limited to once every 6 months.
Oral Hygiene Instruction is limited to 1 per lifetime.
Bitewing x-rays are limited to once every 12 months.
Full Mouth Series X-rays are limited to once every 3 years.
Scaling (root planning) are payable up to 8 units every 12 months.

What You Are Not Covered For
The plan will NOT pay for:
- Dental services or supplies that the insured person is eligible to claim under the Workers' Compensation legislation

- Any dental charges not included in the current Dental Association Suggested Schedule of Fees for General Practitioners
- Cosmetic procedures
- Charges for appointments that are not kept
- Charges for completing claim forms
- Treatment to correct temporomandibular joint dysfunction (The hinge joint of the jaw is called the temporomandibular joint.)
- Any endodontic treatment which was started before the effective date of coverage
- The replacement of dental appliances that are lost, misplaced or stolen
- Any treatment related to orthognathic surgery (remodeling or reconstruction of your jaw)

If you have any questions, please contact your plan sponsor or call NexgenRx toll-free at 1-866-424-0257.

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Travel insurance is designed to cover losses arising from sudden and unforeseen circumstances occurring while temporarily travelling outside your province or territory of residence. It is important to read and understand this plan before travelling.

This booklet includes information on your eligibility, qualifications for eligible dependents, effective and termination dates, and details about your benefits. If you have any questions or need more information, please contact the plan administrator at your place of employment.

The information provided here is a summary of your benefits program and does not in itself constitute an agreement. If there is any discrepancy between this information and the plan master policy and governing documents, the terms of the latter take precedence.

Global Excel Management, Inc. (called "Global Excel") provides medical assistance and claims services under the policy.

IN THE EVENT OF A MEDICAL EMERGENCY, IT IS EXTREMELY IMPORTANT THAT YOU CONTACT GLOBAL EXCEL:
The emergency telephone numbers are listed in this booklet under Contact Information (page 30) and on the back of your medical assistance card.

Global Excel must be contacted before seeking medical treatment or as soon as possible after being admitted to a hospital. Upon verification, Global Excel will confirm eligibility for coverage to the hospital. If a condition renders you unable to contact Global Excel, someone else must advise Global Excel of the situation immediately. It remains your responsibility to ensure that Global Excel has been contacted prior to receiving medical treatment or as soon as is reasonably possible.

VIATOR Out-of-Province/Canada Group Travel Advantage Medical Emergency Insurance and Assistance Program is underwritten by Royal & Sun Alliance Insurance Company of Canada and administered by Expert Travel Financial Security (E.T.F.S.) Inc. (called "ETFS"), a member of the ETFS Financial Group.

TABLE OF CONTENTS FOR TRAVEL INSURANCE

BENEFIT SUMMARY

Overall maximum for all benefits:	$5 million CAD
Medical Referral	Up to $75,000 per lifetime
Hospital	Reasonable & Customary Costs
Incidental Hospital Expenses	Up to $250
Physician	Reasonable & Customary Costs
Prescriptions	30-day supply per prescription Up to $250 for lost prescriptions
Diagnostic Services	Reasonable & Customary Costs
Medical Appliances	Reasonable & Customary Costs
Ambulance Services	Reasonable & Customary Costs
Paramedical Practitioners	$500 per practitioner, per emergency
Nursing Care	Up to $5,000 per emergency

Treatment of Dental Accidents	Up to $2,000
Treatment of Dental Plan	Up to $300
Medical Evacuation	Reasonable & Customary Costs
Return of Travel Companion	One way economy airfare
Family/Friend Hospital Visit	Single round-trip economy airfare, plus up to $150 per day to $3,000
Child Care	Up to $5,000 per trip
Return of Vehicle	Up to $5,000
Meals & Accommodation	Up to $150 per day, $3,000 per trip
Return of Deceased	Up to $5,000

EMERGENCY INCIDENTAL BENEFITS

Alternate Transportation	Up to $5,000
Trip Cancellation	Up to $5,000 per trip
Baggage Insurance	Up to $1,000 per trip
Business Expenses	Up to $1,000 per trip

ELIGIBILITY

1. You must be a permanent resident of Canada;
2. You must be employed in Canada;
3. You must be covered under the Government Health Insurance Plan of your province or territory of residence;
4. You must qualify for coverage under your employer's supplementary health plan;
5. You must be younger than the termination age specified in the Schedule of Benefits; and
6. (a) If you are covered as an employee, you must:

i. work the minimum number of hours per week specified by your employer; and
ii. satisfy the waiting period specified by your employer; or

(b) If you are covered as a member of the policyholder who is other than an employer, you must:

i. be a member in good standing of the policyholder; and
ii. be on the monthly list of members entitled to coverage provided by the policyholder.

Coverage will become effective on the later of:

1. the date the policy becomes effective; or
2. the date you qualify for coverage under the policyholder's supplementary health plan.

Eligible Dependents

Your dependents become eligible for coverage on the date you become eligible or the date they first become your dependent, whichever is later. You must be eligible for coverage in order for your dependents to be eligible. Dependents must have their primary residence with you, and:

1. be covered under the Government Health Insurance Plan of their province or territory of residence;
2. qualify for coverage as a dependent under the policyholder's supplementary health plan.

Spouse

The person to whom you are legally married, or a person with whom you have been residing with for the cohabitation period specified by your employer in the master application.

Dependent Child

Your unmarried child, or the unmarried child of your spouse, who is:

1. under the age limit specified by your employer in the master application; and
2. primarily dependent on you for support; and
3. not employed on a full-time basis; or
4. any age and physically or mentally disabled and totally dependent on you for support.

Note: Coverage for disabled employees or employees who are not actively at work (as indicated in the master application) on the date their coverage would normally become effective will become effective on the date the employee resumes active work, or immediately if the required premiums are paid (except for employees on leave of absence).

Note: You may only provide coverage for one spouse at a time.

Note: Dependents registered for full-time school at an accredited institute of learning outside of Canada are only eligible for benefits that result from an emergency. As such, during an emergency, students may be required to return to their province or territory of residence (see Limitations). Proof of school attendance must be provided at time of claim.

Note: In the event of your death, coverage for dependents will continue for the length of time specified by your employer's supplementary health plan or to the date a dependent ceases to be eligible or remarries (whichever occurs first), provided the policyholder continues to make the required premium payments.

TERMINATION

Coverage will terminate immediately upon the first to occur of:

1. the date you or a dependent cease to meet the above eligibility requirements for coverage;
2. the date employment terminates (voluntary or not);
3. the date the premium is due if the policyholder does not remit your premium, except where this is the result of clerical error; or
4. the date the policy is terminated.

BENEFITS

Referral Benefit

1. Reasonable and customary medical and transportation expenses, in excess of those expenses covered by the insured person's Government Health Insurance Plan, for the insured person and an approved escort, to a lifetime maximum of $75,000, for pre-approved medical referral, subject to the following conditions:

(a) The treatment must be unavailable where the insured person resides and be located at least five hundred (500) kilometres from your residence.
(b) Your attending Canadian physician and a specialist from a related medical field must recommend the treatment.
(c) The expenses must be eligible for reimbursement in whole or in part, under your Government Health Insurance Plan.
(d) Medical services and travel must take place within thirty (30) days of receiving approval from your Government Health Insurance Plan, unless the earliest possible treatment date exceeds thirty (30) days from the date of approval.
(e) All Medical Referrals must be pre-approved and submitted in writing to Global Excel, along with supporting documentation.

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

a) is appropriate and consistent with the diagnosis according to accepted community standards of medical practice;
b) is not experimental or investigative in nature;
c) cannot be omitted without adversely affecting the insured person's condition or quality of medical care; and
d) cannot be delayed until the insured person returns to his province or territory of residence.

Note: "Hospital" means an institution which is designated as a hospital by law; which is continuously staffed by one or more physicians available at all times; which continuously provides nursing services by graduate registered nurses; which is primarily engaged in providing diagnostic services and medical and surgical treatment of a sickness and/or injury in the acute phase, or active treatment of a chronic condition; which has facilities for diagnosis, major surgery and in-patient care. The term hospital does not include convalescent, nursing, rest or skilled nursing facilities, whether separate from or part of a regular general hospital, nor a facility operated exclusively for the treatment of persons who are mentally ill, aged, or drug or alcohol abusers.

Out-of-Province Medical Benefits

An emergency is described as an acute sickness or accidental injury that requires immediate treatment. The emergency treatment must be medically necessary and prescribed by a physician. The emergency must occur while the insured person is travelling outside of their province of residence. Such emergency no longer exists when, in the opinion of Global Excel, the insured person is able to return to his province of residence.

The maximum amount payable for all benefits listed will not exceed five (5) million in Canadian funds per insured person.

The following benefits are payable up to the maximum amounts specified. Reasonable and customary costs are those that do not exceed the standard reimbursement of other providers of similar standing in the same geographical area. Only legally insurable expenses incurred as a result of an emergency in excess of the amount paid by any other insurance will be considered. However, certain expenses, as specified below, are covered only if the prior approval of Global Excel is obtained.

1. **Hospital**

a) Room and board costs up to the private room rate charged by a general public active treatment hospital.
b) The reasonable and customary cost of services provided on an out-patient basis by a general public active treatment hospital.
c) Up to $250 per hospital stay for out-of-pocket expenses such as telephone charges, television rental and parking.
If coverage terminates for any reason during the hospital stay, benefits continue until discharge.

2. **Physician**

Charges for treatment by a physician.

3. **Doctor Prescribed Treatments/Services/Appliances**

The prescription benefits are limited to a 30-day supply per prescription, unless the insured person is hospitalized.
a) Prescriptions: Drugs, including injectable drugs and sera, that can only be obtained upon medical prescription, that are prescribed by a physician and that are supplied by a licensed pharmacist when medically necessary for emergency treatment.
b) Lost Prescriptions: The replacement of lost prescription medication when approved in advance by Global Excel, to a maximum of $250.
c) Diagnostic Services: Laboratory tests and x-rays prescribed by the attending physician that are part of the emergency treatment. Magnetic resonance imaging (MRI), cardiac catheterization, computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies must be authorized in advance by Global Excel.
d) Medical Appliances: The reasonable and customary cost of splints, casts, crutches, canes, slings, trusses, walkers or the temporary rental of a wheelchair when authorized in advance by Global Excel.

4. **Ambulance Services**

When reasonable and medically necessary, licensed ground ambulance service to the nearest medical facility.

5. **Paramedical Practitioners**

The services (including x-rays) of a licensed chiropractor, physiotherapist, podiatrist or osteopath, to a maximum of $500 per practitioner listed above, per emergency, when approved in advance by Global Excel.

6. **Nursing Care**

The services of a nurse, when prescribed by a physician and while hospitalized, to a maximum of $5,000 per insured person, per emergency, when approved in advance by Global Excel. Note: A doctor visit to have the replacement prescription prescribed is eligible if arranged and approved in advance by Global Excel. Note: A professional nurse is a graduate registered nurse, licensed practical nurse, or registered nursing assistant.

7. **Dental Treatment**

a) Treatment of Dental Accidents: Up to $2,000 per insured person for emergency dental treatment to repair natural, vital and sound teeth or permanently attached artificial teeth provided the injury was caused by an external, accidental blow to the mouth or face. The insured person must consult a physician or dentist immediately following the injury. An accident report is required from a physician or dentist for claims purposes.
b) Treatment of Dental Pain: Up to $300 per insured person for the relief of acute dental pain, excluding services related to crowns, root canals or temporomandibular joint dysfunction (TMJ), when treatment is rendered at least five hundred (500) kilometres outside the insured person's province of residence. Note: Dental treatment must begin during the coverage period and be completed prior to the return to the province or territory of residence.

8. **Medical Evacuation**

When approved and arranged in advance by Global Excel:
a) air ambulance to the nearest appropriate medical facility or to a Canadian hospital for immediate emergency treatment; or
b) transport on a licensed airline with an attendant (where required) to return the insured person to his province or territory of residence for immediate emergency treatment.

9. **Return of Travel Companion**

If an insured person is returned to his province or territory of residence under the Medical Evacuation benefit or the Return of Deceased benefit, the insurer will reimburse the cost of a single one-way economy airfare for a travel companion to return to Canada, when approved in advance by Global Excel. Note: A travel companion is any person who accompanies the insured person on the trip, who shares accommodation or transportation with the insured person and who has paid such accommodation and transportation in advance of departure.

10. **Family/Friend Hospital Visit**

When approved in advance by Global Excel, a single round-trip economy airfare from Canada, plus up to $150 per day to a maximum of $3,000, for the cost of meals and commercial accommodation for one person to:
a) be with the insured person if the insured person is travelling alone and has been hospitalized as the result of an emergency. To be payable, this benefit requires that the insured person eventually be hospitalized as an in-patient for at least three (3) consecutive days outside his province or territory of residence and that the attending physician provide written certification that the situation was serious enough to warrant the visit; or

b) identify the deceased insured person prior to the release of the body, where necessary.
The insurer will only reimburse covered expenses evidenced by original receipts.

11. **Child Care**

When approved in advance by Global Excel, to a maximum of $5,000 per trip for one of the following child care assistance benefits:

a) Economy class airfare for the return of dependent children who are under sixteen (16) years of age in the event you or your spouse is hospitalized as a result of an emergency. Where necessary, arrangements will include provision for an escort for the children; or

b) The cost of caregiver services (other than a relative) for dependent children who are under sixteen (16) years of age in the same location where you or your spouse is hospitalized as a result of an emergency; or

c) The cost of caregiver services (other than a relative) for dependent children who are under sixteen (16) years of age in their home province or territory of residence when left unattended due to an emergency involving you or your spouse while travelling.

12. **Return of Vehicle**

Up to $5,000, if neither the insured person, nor someone travelling with him, is able to operate the insured person's vehicle, whether owned or rented, during the trip, due to sickness and/or injury. Arrangements and payment will be made for the return of the vehicle to the home of the insured person in his province or territory of residence or the nearest appropriate rental agency when approved and/or arranged in advance by Global Excel. The insurer will only reimburse covered expenses evidenced by original receipts. Exclusion: Benefits will only be payable for a single person to return the vehicle. This benefit does not cover wages lost by the person driving your vehicle.

13. **Meals and Accommodation**

Up to $150 per day, to an overall maximum of $3,000 per trip, per insured person, for the cost of commercial accommodation and meals when a trip is extended beyond the last day of the scheduled trip due to sickness and/or injury suffered by a travel companion. This benefit must be authorized in advance by Global Excel. The fact that a travel companion is unable to travel must be certified by the attending physician and the claim must be supported with original receipts from commercial organizations. Note: A travel companion is any person who accompanies the insured person on the trip, who shares accommodation or transportation with the insured person and who has paid such accommodation and transportation in advance of departure.

14. **Return of Deceased**

Up to $5,000 towards the cost of preparation and transportation of the deceased insured person to his province or territory of residence, in the event of death due to a sickness and/or injury. In the case of cremation and/or burial at the place of death of the insured person, this benefit is limited to $2,500. The cost of the casket or urn is not covered.

EMERGENCY INCIDENTAL BENEFITS

1. **Alternate Transportation**

When approved in advance by Global Excel, to a maximum of $5,000, if, while travelling, the insured person(s) private vehicle is stolen or rendered inoperable due to an accident, the cost of one way economy airfare(s) will be provided to the insured persons to return to their province of residence. To file a claim, the insured person must supply an official police report of the loss or accident.

2. **Trip Cancellation**

The cost of trip cancellation to a maximum of $5,000 per insured person per trip for any of the following occurrences that prevent an insured person from departing on a scheduled trip. To be payable, the prepaid travel arrangements must be cancelled prior to the scheduled departure date. Only the expenses that are non-refundable on the date of the event forcing cancellation shall be considered for the purpose of the claim. The insured person must contact Global Excel and the supplier of his travel services on the day the event occurs or the next business day to advise of the cancellation. A trip may be cancelled due to one of the following:

a) Death, emergency hospitalization due to sickness or injury, or quarantine of an insured person, a travel companion, an immediate family member, a travel companion's immediate family member, a business partner, a key employee, a caregiver or the host at trip destination. To file a claim, the insured person must supply supporting medical records, or a death certificate.

b) A new formal notice issued by the Canadian Government prior to the date of departure, warning Canadian residents not to travel to a specific region of any country that is part of the trip.

c) The insured person is summoned to perform jury duty or subpoenaed as a witness in a case. This applies only when the trial is scheduled to be heard during the scheduled trip dates and the summons or subpoena is received after the travel arrangements were purchased. This must be substantiated by court documents.

3. **Baggage Insurance**

The cost of replacement of an insured person's luggage to a maximum of $1,000 per insured person per trip due to theft, damage or loss by a bus, taxi, train, boat, airplane or other vehicle which is licensed, intended and used to transport

paying passengers. Reimbursement will be limited to the actual cash value or the maximum specified, whichever is less, with respect to any one item or set of items. Exclusion: Baggage insurance does not cover: animals, cash, securities, credit cards and any other negotiable instruments, luggage not checked, luggage held seized, quarantined or destroyed by customs or any other government agency.

4. **Business Expenses**

Business expenses to a maximum of $1,000 per insured person per trip for the temporary use or rental of a computer or portable phone in the event of theft provided such use or rental is required in connection with the business, trade or professional occupation of the insured person.

Original receipts and a police report are required for reimbursement.

TRAVEL ASSISTANCE BENEFITS

Global Excel is available to take your calls 24 hours a day, 7 days a week. No matter where you travel, professional assistance personnel are ready to take your call. Global Excel can also provide you with Canada Direct instructions and codes so that you only deal with Canadian telephone operators.

Medical Assistance Services

Global Excel will:

1. Assist in locating an appropriate physician, clinic or hospital;
2. Confirm coverage and arrange direct billing with the hospital or physician;
3. Monitor and supervise medical treatment and keep the family informed;
4. Arrange for approved transportation of a family member to the patient's bedside;
5. Arrange to transport the patient home, if medically permissible.

Note: Immediate family members are limited to: spouse, son, daughter, father, mother, brother, sister, stepson, stepdaughter, stepfather, stepmother, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandson, granddaughter, grandfather, or grandmother.

General Assistance Services

Global Excel will:

1. Provide emergency response in most major languages;
2. Assist in contacting your family, business partner or family physician;
3. Arrange for the transmission of urgent messages to family members or business partners;
4. Assist in the event of lost passports or airline tickets;
5. Coordinate claims submission and negotiate health care provider discounts;
6. Coordinate claims processing with government health plans.

EXTENSION OF COVERAGE

An automatic seventy-two hour (72-hour) extension of coverage will be granted to insured persons who have not reached the termination age, if scheduled return is delayed due to:

1. a medical emergency or the insured person being hospitalized on the last day of coverage. The coverage of the insured person will remain in force for as long as the insured person is hospitalized and the 72-hour extension commences upon release from hospital;
2. a late train, boat, bus, plane or other vehicle in which an insured person is a passenger (including by reason of inclement weather);
3. the private vehicle in which the insured person is travelling is involved in a traffic accident or mechanical breakdown.

To file a claim incurred after your original scheduled return date, you must supply proof of the event resulting in your delayed return.

Note: Whenever possible, Global Excel will instruct the hospital, clinic or physician to bill the insurer directly and arrange direct payment of covered expenses.

Note: Global Excel will ensure you receive the necessary claim forms and will answer any questions regarding your claim, the standard verification procedures and/or the way the policy benefits are administered.)

LIMITATIONS

1. Benefits are payable for expenses incurred only during the period the contract is in force.
2. You must contact Global Excel and your supplier of travel services on the day the event forcing trip cancellation occurs or the next business day to advise them of the cancellation. Failure to notify Global Excel may limit the benefits payable to you.
3. If you incur expenses without prior approval from Global Excel, reimbursement may be limited to the reasonable and customary costs for any treatment received. You will be responsible for paying any difference between the amount incurred and the reasonable and customary costs.

4. Global Excel reserves the right to limit the benefits payable, or may not accept liability for hospitalization and related services if the assistance centre is not contacted within twenty-four (24) hours of admission. Failure to contact the assistance centre may result in the payment of medical expenses being denied or delayed.
5. During an emergency, whether prior to admission or during a covered hospitalization, Global Excel reserves the right to transfer the insured person to another hospital or return the insured person to their province or territory of residence. Refusal to comply with the transfer request will absolve the insurer of any further liability related to the emergency.
6. Once the insured person is deemed medically stable to return to Canada (with or without medical escort) either in the opinion of Global Excel or by virtue of discharge from a medical facility, the emergency will be deemed to have ended, whereupon any further consultation, treatment, recurrence or complication related to the emergency will no longer be eligible for coverage under this policy.
7. Neither Global Excel nor the insurer shall be responsible for the availability, quality or results of any medical treatment or transportation or the failure of the insured person to obtain medical treatment.

Note: A medical condition is considered stable if:
- There has been no new diagnosis, treatment or prescribed medication;
- There has been no change in treatment or change in medication, including the amount of medication to be taken or how often it is taken.
- There have been no new symptoms, more frequent symptoms or more severe symptoms;
- There have been no test results showing deterioration;
- There has been no hospitalization or referral to a specialist (made or recommended) and test results or further investigations for the medical condition must not be pending.

EXCLUSIONS

This policy does not cover losses or expenses caused directly or indirectly, in whole or in part, by any of the following:
1. A trip cancelled due to hospitalization for a pre-existing medical condition if at any time in the ninety (90) days prior to the purchase of the travel arrangements the medical condition was not stable.
2. Any trip booked or commenced contrary to medical advice or after receipt of a terminal prognosis.
3. Treatment or services normally covered or reimbursable under a Government Health Insurance Plan or under other insurance the insured person may have.
4. Treatment or surgery during a trip when the trip is undertaken for the purpose of securing or with the intent of receiving medical or hospital services, whether or not such trip is taken on the advice of a physician (except under the terms of the Referral Benefit).
5. Treatment, surgery, medication, services or supplies that are not required for the immediate relief of acute pain and suffering or that the insured person elects to have provided outside his province or territory of residence when medical evidence indicates that the insured person could return to his province or territory of residence to receive such treatment. The delay to receive treatment in the province or territory of residence has no bearing on the application of this exclusion.
6. Treatment not performed by or under the supervision of a physician, licensed dentist, or a paramedical practitioner.
7. Services or supplies related to any of the following:
a) a general health examination for "check-up" purposes, or routine ongoing care, or related care of a medical condition when the initial emergency has ended (as determined by Global Excel);
b) home health care, chronic care, or the chronic unit of a general hospital, Long Term Care Facility, or nursing home;
c) care in a psychiatric hospital;
d) rehabilitation or ongoing care in connection with drugs, alcohol or any other substance abuse; or non-compliance with any prescribed medical therapy or treatment;
e) a rest cure, health spa, exercise program, weight reduction clinic or travel for health purposes;
f) experimental drugs (not formally approved by the regulatory bodies in Canada or the U.S.) or investigative services;
g) vitamins, food supplements and over-the-counter drugs or medicines, whether prescribed or not; or
h) cosmetic or elective services.
8. Services or supplies related to any of the following:
a) a disorder, disease, condition or symptom that is emotional, psychological or mental in nature unless the insured person is hospitalized;
b) suicide (including any attempt thereat) or self-inflicted injury, whether or not the insured person is sane;
c) abuse or overdose of prescribed medication, toxic substances, alcohol or non-prescription drugs;
d) driving a motorized vehicle while impaired by drugs, toxic substances or an alcohol level of more than 80 milligrams in 100 millilitres of blood; or
e) commission of or attempt to commit, directly or indirectly, an illegal act or a criminal act.
9. Participation in and/or voluntary exposure to any risk from: war or act of war, whether declared or undeclared; invasion or act of foreign enemy; declared or undeclared hostilities; civil war, riot, rebellion; revolution or insurrection; act of military power; or any service in the armed forces.
10. Sickness, injury or medical condition suffered or contracted by the insured person in a specific country, region or area for which the Department of Foreign Affairs and International Trade of the Canadian Government has issued a travel advisory or formal notice, before the insured person's departure date, advising Canadians not to travel to that specific country, region or area.

If the Canadian Government issues a travel advisory or formal notice to leave that specific country, region or area, after the insured person's departure date, coverage for sickness, injury or medical condition is limited to a period of 10 days from the date the advisory was issued, or to a period that is reasonably necessary to safely evacuate the country, region or area. In this exclusion,

"sickness, injury or medical condition" means any sickness, injury or medical condition that is attributable to the reason for which the travel advisory or formal notice was issued or any complications arising therefrom.
11. Treatment, hospitalization or expenses caused by:
a) participation in any sport as a professional athlete (person who engages in an activity as one's main paid occupation);
b) participation in any competitive motorized sporting events, racing or speed contests;
c) scuba diving (unless you hold a basic SCUBA designation from a Canadian certified school), hang gliding, rock climbing, paragliding, skydiving, parachuting, bungee jumping or mountaineering; or
d) a flight accident unless the insured person is riding as a fare paying passenger on a commercial airline or charter aircraft with a seating capacity of six people or more.
12. Treatment or hospitalization of mother or child as a result of:
a) pregnancy, miscarriage, childbirth or complications of any of these conditions occurring in the eight (8) weeks before or after the expected delivery date; or
b) a pregnancy being deemed a high risk pregnancy by a physician, at any time; or
c) induced abortion.
13. Dental Services related to crowns, root canals or temporomandibular joint dysfunction (TMJ).
14. Baggage insurance does not cover: animals, cash, securities, credit cards and any other negotiable instruments, luggage not checked, luggage held seized, quarantined or destroyed by customs or any other government agency.

Exceptions: the routine adjustment of Coumadin, Warfarin, insulin or oral medication to control diabetes (as long as they are not newly prescribed or stopped) and a change from a brand name medication to a generic brand medication (provided that the dosage is not modified.)
Note: A high risk pregnancy is one in which any cause places the mother, the developing fetus, or both at risk and the mother is on leave from her regular employment in order to reduce or avoid such risk.

Note: All coordination follows the Canadian Life and Health Insurance Association guidelines.

GENERAL PROVISIONS

1. Other Insurance

If other insurance exists, the insurer will pay covered expenses only in excess of those covered by that other insurer or other responsible party. This includes insurance from credit cards, private or public health plans, private or provincial auto plans, or any other insurance, whether collectable or not, which provides some or all of the benefits and coverage provided under this policy.

If, however, the other insurance is also "excess only", the covered expenses will be coordinated so that payment from all benefit plans (group, individual or government) does not exceed 100 percent of the eligible expense.

2. Co-ordination of Benefits

If you have similar group benefits through any other insurer, the amount payable through this plan shall be coordinated so that payment from all benefit plans (group, individual or government) does not exceed 100 percent of the eligible expense.

When both plans include the co-ordination of benefits provision, expenses should be submitted to the plan that covers the person as an employee first. For dependent children, expenses should first be submitted to the plan of the spouse whose birthday falls first in the year.

3. 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 insured person's rights, powers, privileges, and remedies, to the extent of benefits paid under this policy, against any person, legal person or entity which caused such loss. Additionally, if "no fault" benefits or other collateral sources of payment of medical expenses are available to the insured person, regardless of fault, the insurer is granted the right to make demand for, and recover, those benefits. If the insurer institutes an action it may do so at its own expense, in the name of the insured person, and the insured person will attend at the place of loss to assist in the action, in addition to providing the insurer all information, cooperation and assistance as the insurer may reasonably require. If the insured person institutes a demand or action for a covered loss, the insured person shall immediately notify the insurer so that the insurer may safeguard its rights.

Notwithstanding any provisions in this policy to the contrary, the insurer's rights under this paragraph shall be governed by the laws of the state, province, or district where the loss occurs, or where benefits under this policy are paid.

The insured person shall take no action after a loss that will impair the rights of the insurer set forth in this paragraph and shall do all such things as are necessary to secure such rights.

4. Examination of the Policy

The policy, including any endorsements, will be kept at the office of the policyholder. You may request to consult the policy during the regular business hours of the policyholder.

5. Evidence of age

The insurer reserves the right to request proof of age of any insured person.

CLAIMS

Your benefit plan permits direct payment to providers. Whenever possible Global Excel will arrange for direct billing with providers, and you may choose to assign benefits to the provider of the service (hospital, clinic, physician). To facilitate direct billing be sure to

present your medical assistance card to the provider.

Claims submitted directly must include all original receipts and a completed claim form including the following information:

1. Your name and complete address;
2. Canadian provincial or territorial Government Health Insurance Plan number with its expiry date or version code (if applicable);
3. Claimant's date of birth, name and, if applicable, relationship to you;
4. Proof of the departure date(s) and return date(s);
5. All original prescription drug receipts (not cash register receipts), and/or itemized bills from the medical provider(s) stating the date(s) of the service(s) provided, the diagnosis, all dates and types of treatment, and the name of the medical facility and/or physician;
6. For trip cancellation claims, the original airline tickets, electronic copy of your airline booking if applicable, and/or proof of all requested applicable refunds;
7. For baggage insurance, a report by the police and one of either the hotel manager, tour guide or transportation authorities in whose custody the insured property was at the time of loss, and adequate proof of loss, ownership and itemized value along with a detailed statement.
8. For medical evacuation claims, the unused portion of the insured person's air ticket must be returned to Global Excel.

Note: You must sign and return the authorization form to allow Global Excel to recover payment from the Canadian provincial or territorial Government Health Insurance Plan.
Note: Covered expenses are the lesser of actual expenses or reasonable and customary charges for the covered services or supplies.
Note: Claims must be submitted within 12 months from the date of service to be reimbursed under this plan.

Currency

All sums in the plan are in Canadian currency unless otherwise indicated. If you have paid a covered expense in a currency other than Canadian currency, you will be reimbursed in Canadian currency at the prevailing rate of exchange on the date that the claim payment is made. This insurance will not pay interest.

Processing and Submission Timeframes

Settling a medical emergency claim involves several steps. Due to the complexity of travel claims, please allow a minimum of 4-6 weeks for the submission of medical records, itemized invoices, and documentation review. Additional information pertinent to your claim may be required by Global Excel, and it is very important for you to provide requested information in a timely manner.

To facilitate the process, submit claims as soon as possible after the date of service. This significantly increases our ability to obtain any required additional information, and allows us to maximize cost containment attempts. On termination of coverage (for any reason), claims for services incurred prior to the termination date must be submitted within 90 days of the termination date.

CONTACT INFORMATION for Viator Travel Insurance:

In the event of a TRAVEL emergency, call:
Canada/USA, toll free 1-866-870-1898
Collect 1-819-566-1898

Trip Cancellation/Baggage Insurance Desk, call:
Canada/USA, toll free 1-877-644-4215
Collect 1-819-566-4215

To purchase Top-Up coverage, (over 60 days) call:
Canada/USA, toll free 1-877-832-6025
Collect 1-819-566-2066

For claims, submit documentation to:

Global Excel Management, Inc.
73 Queen Street
Lennoxville, Quebec
J1M 1J3

For travel ins. claim status, call during regular business hours:
Canada, toll free 1-866-870-1898
Collect 1-819-566-1898

All other inquiries should be directed to your plan administrator.

The above is a registered trademark of Global Excel Management Inc., a member of the ETFS Financial Group: the Global Excel logo.

PROTECTING YOUR PRIVACY
For privacy information, please see www.royalsunalliance.ca, or call 1-800-716-4339.

We at ETFS recognize and respect every individual's right to privacy. When you apply for benefits, we establish a confidential file of your personal information. We use the information to administer the benefit plan under which you are covered. This includes many tasks, such as:

- Determining your eligibility for coverage under the plan;
- Assessing your claims and providing you with payment;
- Managing your claims;
- Verifying and auditing eligibility and claims; and
- Underwriting activities, such as determining the cost of the plan and analyzing the design options of the plan.

We limit access to information in your file to staff, to persons authorized by us who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We may also exchange information, when necessary to administer the benefit plan, with your health care provider, other insurance and reinsurance companies, and your plan administrator.

CRITICAL ILLNESS COVERAGE FOR YOUR SUCCESSFUL RECOVERY AND PEACE OF MIND

People are living longer lives due to healthier lifestyles and advances in medical science which results in a greater number of people surviving illnesses that were once fatal. While we are beating the odds, an alarming number of Canadians will suffer a critical illness in their lifetime. For example:

- 1 in 2 Canadians will contract some form of Heart Disease
- 1 in 3 Canadians will develop some form of life threatening Cancer
- 1 in 4 Canadians will suffer Kidney Failure
- 1 in 20 Canadians will run the risk of having a Stroke before age 70
- 1 in 500 is the incidence rate for Multiple Sclerosis

But, having survived a critical illness, many people are unable to swiftly return to work and are in need of special medical attention or other care. Until recently, coverage for such unexpected needs just wasn't available and while disability insurance provides income protection, it doesn't adequately provide financial assistance for such expenses as:

- Convalescence
- Lifestyle Changes
- Home Modification
- Supplementary Income
- Home Care
- Pension Supplement
- Dependent Care
- Medical Expenses (not covered by government or private health plans)

ACE INA Life Insurance Group Critical Illness program was developed to address these needs and therefore alleviate some of the stress and financial burden resulting from a critical illness.

ELIGIBILITY

You will be eligible for coverage if you are an active, permanent, full-time employee of the Policyholder working a minimum of 20 hours per week, under age 65.

Coverage can also be purchased by your spouse (legally married or a person who co-habits with you and has been represented as your domestic partner for a period of 1 year or longer in the community in which you reside and continues to be so represented) under age 65 or unmarried dependent children, including step, foster or legally adopted children who are under age 21 or under age 25 if the child is in full-time attendance as a student of an accredited institute of higher learning and who is dependent upon you or your spouse for financial support. A child who is dependent by reason of mental infirmity will also be eligible for coverage beyond the maximum age noted, provided that they are incapable of self sustaining employment and are dependent upon you or your spouse for support and maintenance.

INSURED CONDITIONS

- Alzheimer's Disease
- Aorta Surgery
- Benign Brain Tumour
- Blindness
- Cancer
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Dismemberment
- Heart Attack
- Heart Valve Replacement
- Loss of Speech
- Major Organ Failure
- Major Organ Transplant
- Motor Neuron Disease
- Multiple Sclerosis

- Occupational HIV Infection
- Paralysis
- Parkinson's Disease
- Severe Burns
- Stroke

ADDITIONAL BENEFITS
- Ductal Carcinoma in situ (DCIS) Benefit
- Early Stage Prostate Cancer (T1a or T1b) Treatment
- Hip or Knee Replacement Surgery
- Loss of Independence Benefit
- Second Event Benefit

BENEFITS
Mandatory Coverage
You will be covered for a flat amount of $5,000. This is in addition to any group critical illness coverage you may have in force.

PAYMENT TERMS
If, while coverage is in effect:
a) but only after coverage has been in effect on the Insured Person for a period of 90 days, the Insured Person, is then diagnosed with DCIS or Cancer, or undergoes Early Stage Prostate Cancer (T1a or T1b) Treatment, whether included or excluded in the policy, or if any symptoms or medical problems manifest themselves which, or the persistence or recurrence of which, subsequently results in an investigation leading to the diagnosis of cancer, and the Insured Person survives for a period of 30 days thereafter, ACE INA Life Insurance will pay the principal sum; or
b) the Insured Person, is then diagnosed with Alzheimer's Disease, Benign Brain Tumour, Blindness, Coma, Deafness, Dismemberment, Heart Attack, Loss of Independence, Loss of Speech, Major Organ Failure, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Occupational HIV, Paralysis, Parkinson's Disease, Severe Burns or Stroke, and the Insured Person survives for a period of 30 days thereafter (180 days for Paralysis), ACE INA Life Insurance will pay the principal sum; or
c) the Insured Person, undergoes Aorta Surgery, Coronary Artery Bypass Surgery, Heart Valve Replacement or Hip or Knee Surgery and the Insured Person survives for a period of 30 days thereafter, ACE INA Life Insurance will pay the principal sum.

PARTIAL BENEFITS

DUCTAL CARCINOMA IN SITU (DCIS) BENEFIT OR EARLY STAGE PROSTATE CANCER (T1a or T1b) TREATMENT
Subject to the terms, conditions and other provisions of the policy, ACE INA Life Insurance will pay the Insured Person 20% of the principal sum up to a maximum of $20,000 if, while insured, the Insured Person is diagnosed with DCIS or undergoes Early Stage Prostate Cancer (T1a or T1b) Treatment and survive 30 days thereafter.
This benefit is payable only once, without interest. Payment of this benefit reduces the principal sum the Insured Person selected on the Critical Illness enrolment form. Payment of this benefit will represent full and final discharge of all claims under this benefit.

LOSS OF INDEPENDENCE BENEFIT
Subject to the terms, conditions and other provisions of the policy, ACE INA Life Insurance will pay the Insured Person 25% of the principal sum if, while insured, the Insured Person is diagnosed with Loss of Independence.
The Loss of Independence Benefit is payable only once, without interest. Payment of the Loss of Independence Benefit reduces the principal sum the Insured Person selected on the Group Critical Illness enrollment form. Payment of the Loss of Independence Benefit will represent full and final discharge of all claims under the Loss of Independence Benefit.

HIP OR KNEE REPLACEMENT SURGERY BENEFIT
Subject to the terms, conditions and other provisions of the policy, ACE INA Life Insurance will pay the Insured Person 10% of the principal sum up to a maximum of $10,000 if, while insured, the Insured Person undergoes surgery to replace either the hip or the entire knee as defined below (see Definitions).
The Hip or Knee Replacement Surgery Benefit is payable only once, without interest. Payment of the Hip or Knee

Replacement Surgery Benefit reduces the principal sum the Insured Person selected on the Group Critical Illness enrollment form. Payment of the Hip or Knee Replacement Surgery Benefit will represent full and final discharge of all claims under the Hip or Knee Replacement Surgery Benefit.
The Hip or Knee Replacement Surgery Benefit is not payable if the principal sum has already been paid as a result of the Insured Person suffering or undergoing one of the insured conditions.

SECOND EVENT BENEFIT (applicable to Insured Employee only)
If an Insured Person is diagnosed with either of the following:
Category of Conditions
a) Cancer, or
b) Cardiovascular Condition (defined as Heart Attack, Stroke, Coronary Artery Bypass, undergoes Aorta Surgery or Heart Valve Replacement)
for which the Principal Sum has been paid and the Insured Person is thereafter considered (by the treating Physician) fully recovered and has returned to work for a period of at least 90 days and is then diagnosed with another Insured Condition, the Second Event Benefit payable will be equal to the Principal Sum (less any partial payment benefit paid after the first principal sum was fully paid). The Second Event Benefit is subject to the Insured Person surviving 30 days after the diagnosis of such Insured Condition.
In order to be considered an eligible second event condition, the first and second event cannot fall into the same Category of Conditions.
The Second Event Benefit is payable only once. Payment of the Second Event Benefit will represent full and final discharge of all claims under the Second Event Benefit. Following Payment of the Second Event Benefit, coverage under this policy will terminate.

Partial Benefits are not considered an event and therefore are not included in the above definition of Second Event. Any benefit payment made will reduce the amount payable under either a First or Second Event.

PRE-EXISTING MEDICAL CONDITION PROVISION
If you or your covered dependents suffer a sickness or sustain an injury for which medical advice, consultation, investigation, or diagnosis was sought or received, or for which treatment was required or recommended by a licensed medical practitioner during the 24 months immediately prior to you or your covered dependent's effective date of insurance or prior to any increase in the amount of insurance and, which directly or indirectly causes the specified covered condition to occur within the first 24 months from you or your covered dependent's effective date of insurance or from any increase in the amount of insurance, a benefit will not be payable.

DEFINITIONS
Alzheimer's Disease: means the diagnosis that the Insured Person has Alzheimer's Disease, which is a progressive degenerative disease of the brain. The diagnosis must be supported by medical evidence that the Insured Person exhibits the loss of intellectual capacity resulting in impairment of their memory and judgment, which results in a significant reduction in their mental and social functioning, such that they require permanent daily personal supervision for the activities of daily living. All other dementing organic brain disorders and psychiatric illnesses are excluded from this insured condition definition. A physician who is certified as either a neurologist or a psychiatrist must confirm diagnosis in writing.

Aorta Surgery: means surgery to the aorta that is medically required to treat disease of the aorta and that involves the excision and surgical replacement of the diseased aorta with a graft. The Aortic Surgery must be performed on the prior written advice of a physician certified as a cardiovascular surgeon. Aorta includes the thoracic and abdominal aorta but does not include any of the branches of the aorta.

Benign Brain Tumour: means a benign neoplasm in the brain or meninges with histologic confirmation. Cysts granulomas, malformations of intracranial arteries or veins, and tumours or lesions of the pituitary are specifically excluded. The diagnosis must be confirmed neuro-radiologically by a specialist trained in the interpretation of radiological investigations.

Blindness: means the total and irrecoverable loss of sight in both eyes due to injury or sickness. Corrected visual acuity must be 20/200 or less in both eyes and the field of vision must be less than 20 degrees in both eyes. A physician certified in ophthalmology, must clinically confirm the diagnosis in writing.

Cancer: means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. This includes Leukemia, Hodgkin's Disease and invasive melanoma but does not include:
- Carcinoma in situ
- Kaposi's Sarcoma (or other AIDS related cancers) and cancer in the presence of human immunodeficiency virus (HIV).
- Skin cancer or melanoma that is not invasive and has not exceeded .75 millimeters in depth.
- Prostate cancer diagnosed as T1 N0M0 or equivalent staging.
- A recurrence or metastasis of a cancer which was originally diagnosed prior to the effective date of coverage.

A physician certified as an oncologist must confirm diagnosis in writing.
Coma: means you have been in a state of unconsciousness for a continuous period of at least 96 hours, during which external stimulation produced no more than primitive avoidance reflexes. A physician who is certified as a neurologist must confirm diagnosis in writing.

Coronary Artery Bypass Surgery: means surgery performed by a physician who is certified as a cardiovascular surgeon to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Non-surgical techniques such as balloon angioplasty, laser relief of an obstruction, or other intra-arterial techniques will not be considered to be a covered Critical Illness.

Deafness: means the diagnosis of permanent loss of hearing in both of your ears, with an auditory threshold of more than 90 decibels in each ear. A physician, who is certified as an otolaryngologist must confirm diagnosis in writing.
Dismemberment: means a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of Loss of Limbs must be made by a Specialist.

Ductal Carcinoma in situ (DCIS): means the diagnosis by a licensed physician, of the presence of ductal carcinoma in situ of the breast, as confirmed by a biopsy. A physician certified as an oncologist must confirm the diagnosis in writing.
Early Stage Prostate Cancer (T1a or T1b) Treatment: means the diagnosis must be made by a specialist. No benefit will be payable unless the specialist has recommended one of the following treatments:
- Prostate Surgery
- Radiation Therapy
- Chemotherapy
- Hormone Therapy

Heart Attack: means a definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:
a) heart attack symptoms; or
b) new electrocardiogram (ECG) changes consistent with a heart attack; or
c) development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.
The diagnosis of Heart Attack must be made by a Specialist.
Exclusions: No benefit will be payable under this condition for:
a) elevated biochemical cardiac markers with a:
(i) Troponin Level of less than 1
(ii) CK-Mb Level of less than 4, or
b) ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.
Heart Valve Replacement: means undergoing surgery to replace any heart valve with either a natural or mechanical valve. The surgery must be determined to be medically necessary by a Specialist.
Exclusion: No benefit will be payable under this condition for heart valve repair.
Hip or Knee Replacement Surgery: means the insured person has undergone surgery to replace either the hip or the entire knee through the procedures defined below:
- Hip replacement qualifies if the femoral stem is replaced. This procedure is performed in both total arthroplasty and hemiarthroplasty (both monopolar and biopolar)
- Knee replacement qualifies if all three compartments of the knee (medial, lateral and patellofemoral compartments) are replaced. This procedure is also known as total knee replacement.

The surgery must be performed by a Specialist

Loss of Speech: means the definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of Loss of Speech must be made by a Specialist.

Loss of Independence: means the definitive diagnosis by a licensed physician of either:
- Being totally and permanently unable to perform, by oneself, at least 2 of the 6 activities of daily living or,
- Cognitive impairment.

A mental or nervous disorder without a demonstrable organic cause is not covered. Loss of Independence must persist for at least 90 days from the date of the diagnosis.

Major Organ Failure: means the irreversible failure of the entire heart, entire liver, entire pancreas (pancreatic islet cell transplants are excluded) both lungs, both kidneys or bone marrow, in which the affected organ is unresponsive to any treatment and for which the Insured Person medically required to become enrolled in a recognized Canadian transplant program to become the recipient of a heart, a liver, a pancreas, a lung, or a kidney or to receive a bone marrow transplant.

Major Organ Transplant: means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a Specialist.

Motor Neuron Disease: means a definite diagnosis of one of the following:
- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- Primary lateral sclerosis
- Progressive spinal muscular atrophy
- Progressive bulbar palsy
- Pseudo bulbar palsy

The diagnosis of Motor Neuron Disease must be made by a Specialist.

Multiple Sclerosis: means the unequivocal written diagnosis by a Physician who is certified as a neurologist confirming at least one of the following:
- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or
- well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

Occupational HIV Infection: means a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of the effective date of the policy, the effective date of last reinstatement of the policy, or the Insured Person's effective date of coverage.

Payment under this condition requires satisfaction of all of the following:

a) The accidental injury must be reported to the insurer within 14 days of the accidental injury;

b) A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;

c) A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;

d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America;

e) The accidental injury must be reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

The diagnosis of Occupational HIV Infection must be made by a Specialist.

Exclusion: No benefit will be payable under this condition if:
" The Insured Person has elected not to take any available licensed vaccine offering protection against HIV; or,
" A licensed cure for HIV infection is available prior to the accidental injury; or,
" HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis: means the total and irrecoverable loss of function of two (2) or more limbs through neurological damage due to injury or sickness, provided such loss of function continually lasts for 180 consecutive days and such loss of function

is thereafter determined on evidence satisfactory to ACE INA Life Insurance to be permanent. A Physician certified as a neurologist must confirm diagnosis in writing.

Parkinson's Disease: means unequivocal diagnosis of primary idiopathic Parkinson's Disease resulting in the inability to perform 3 of the 6 activities of daily living without assistance. Diagnosis should show signs of progressive impairment and must be confirmed in writing by a physician who is certified as a neurologist.
Severe Burns: means the Insured Person has third degree burns covering at least 20% of the surface area of their body. A physician who is certified as a plastic surgeon must confirm diagnosis of this condition in writing.
Stroke: means that the Insured Person has suffered a cerebrovascular incident, excluding transient ischemic attack (TIA), producing infarction of brain tissue due to thrombosis, hemorrhage from an intracranial vessel or embolization caused by an extracranial source. There must be evidence of permanent neurological deficit persisting for 30 consecutive days, supported by evidence that the deficit is resulting from the Stroke, confirmed in writing by a physician who is certified as a neurologist.

LIMITATIONS & EXCLUSIONS
The plan does not provide benefits for any of the specified coverages caused directly or indirectly by or resulting from intentionally self-inflicted injury, suicide or any attempt thereat, while sane or insane; declared or undeclared war or any act thereof; injury or sickness, other than one of the specified coverages, even though such injury or sickness may have been complicated by one of the specified coverages; a complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS Related Complex; the use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel; the commission or attempted commission by the Insured Person of any act which if adjudicated by a court would be an illegal act under the laws of the jurisdiction where the act was committed; misuse of medication or the abuse of drugs or intoxicants; or a pre-existing medical condition except where coverage has been in effect for a period of 24 months following your or your covered dependent's effective date of coverage.

CONTINUANCE OF COVERAGE
If the Insured Person is (1) laid-off on a temporary basis, (2) temporarily absent from work due to short-term disability, (3) on leave of absence, or (4) on maternity leave, coverage shall be extended for a period of 12 months following the beginning of any such event subject to continued payment of premium.

WAIVER OF PREMIUM
If an Insured Person, under age 65, becomes Totally Disabled for 6 consecutive months, while the policy is in force and the Insured Person provides evidence of Total Disability satisfactory to ACE INA Life Insurance, ACE INA Life Insurance will then waive the payment of each premium which falls due with respect to the Insured Person and any insured dependents. Subject to all the terms and conditions of the policy, waiver of any premium as herein provided will continue with respect to the Insured Person until age 65 or earlier termination of the policy. If the Insured Person ceases to be disabled and he/she returns to employment with the Policyholder and is a member of an eligible class, insurance with respect to the Insured Person may be continued upon resumption of premium payments by the Insured Person or the Policyholder.
If after 120 days, an Insured Person receives approval of any Long Term Disability claim provided under a policy of group insurance through the Employer, ACE INA Life Insurance will then waive the payment of each Critical Illness insurance premium subject to the terms stated above.
Recurrent Disabilities
When an Insured Person becomes Totally Disabled again from the same or related causes within 6 months of cessation of the Waiver of Premiums, then all such recurrences will be considered a continuation of the same disability and ACE INA Life Insurance will waive the 6 month qualification period.
If the same disability recurs more than 6 months after cessation of the Waiver of Premiums, such disability will be considered a separate disability. Two disabilities which are due to unrelated causes are considered separate disabilities if they were separated by a return to work of at least 1 day.
Termination of Waiver of Premium
Waiver of Premiums will cease on the earliest of:
a) the date the Insured Person ceases to meet the policy's definition of Totally Disabled;
b) the date the Insured Person does not supply ACE INA Life Insurance with appropriate medical evidence as deemed necessary by ACE INA Life Insurance;
c) the date the Insured Person is no longer receiving regular, ongoing care and treatment of a physician appropriate for the disabling condition, as determined by ACE INA Life Insurance;

d) the date the Insured Person does not attend a medical, psychiatric, psychological, functional, educational and/or vocational examination evaluation by an examiner selected by ACE INA Life Insurance;
e) the date the Insured Person turns 65;
f) the date the policy terminates; or
g) the date the Insured Person dies.

Coverage During Waiver of Premium

While premiums are being waived, Critical Illness Insurance under the policy on the Insured Person and their dependents will continue to be in force. The amount of such Critical Illness Insurance will be the amount of insurance that was in effect on the date of commencement of the disability, subject to any age reduction or termination shown in the policy. "Totally Disabled or Total Disability" with respect to waiver of premium means disability resulting from injury or sickness which prevents engagement in the Insured Person's regular occupation for 6 consecutive months.

CONVERSION

On the date of termination of employment or during the 31 day period following termination of employment, you may convert your insurance to an individual insurance policy of ACE INA Life Insurance. The individual policy will be effective either as of the date that ACE INA Life Insurance receives the application or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same as a person would ordinarily pay when applying for an individual policy at that time. Application for an individual policy may be made at any office of ACE INA Life Insurance. The amount of insurance benefit converted to shall not exceed that amount issued during employment up to an all policies combined maximum of $25,000.

HOW TO CLAIM

In the event of a claim, claim forms can be obtained from the Plan Administrator.

IMPORTANT

This brochure has been prepared in connection with a group plan underwritten by ACE INA Life Insurance. For ease of reference it contains a brief description only and does not mention every provision of the policy issued. Please remember that rights and obligations are determined in accordance with the policy and not this brochure. For the exact provisions applicable, please consult your Plan Administrator.