myHSA – basic
Catastrophic Medical Insurance

Policy # MYH1001- Policyholder Number

Name of Broker

THE WAWANESA LIFE INSURANCE COMPANY

400-200 Main Street, Winnipeg, MB R3C 1A8
Toll Free: 1-888-997-9965 wawanesalife.com

Table of Contents

Insuring Agreement 1
Schedule 2
General Policy Definitions 4
General Policy Provisions 7
1 - Eligibility for Insurance 7
1.1 Eligibility 7
1.2 Participation in the Insurance Plan 7
2 - Effective Date of Individual Insurance 7
2.1 Employee Insurance 7
2.2 Spouse and Dependent Children 8
2.3 Effective Hour on Effective Date 8
2.4 Actively at Work 8
3 - Change in Coverage of an Insured Person 8
4 - Termination of Individual Insurance 9
4.1 Employee 9
4.2 Dependents 9
5 - Continuation of Individual Coverage 10
5.1 Continuation of Coverage 10
5.2 Reinstatement of Individual Coverage 11
6 - Claims 11
6.1 Beneficiary 11
6.2 Notice and Proof of Claim 11
6.3 Insurer to Furnish Forms for Proof of Claim 12
6.4 Failure to Give Notice or Proof 12
6.5 Reserving Rights 12
6.6 Fraudulent Claims 12
6.7 Limitation of Action 13
6.8 Subrogation 13
6.9 Recovering Overpayments 13
6.10 Coordination of Coverage 13
6.11 Settlement Options 13
6.12 Extension of Coverage under Previous Insurer 13
7 - Premiums 14
8 - Contract 14
8.1 Administration 14
8.2 Clerical or Mechanical Errors 14
8.3 Conformity to Legislation 14
8.4 Currency 14
8.5 Entire Contract 14
8.6 Insurance Data 15
8.7 Material Facts 15
8.8 Insured Right of Access 15
8.9 Misrepresentation and Incontestability 15
8.10 Misstatement of Age 15
8.11 Non-Participating 15
8.12 Replacement 16
8.13 Renewal of Contract 16
8.14 Responsibility of the Policyholder 16
8.15 Termination by the Group/Association 16
8.16 Termination by the Insurer 16

8.17 Termination by the Policyholder ... *16*
8.18 Waiver ... *16*
Coverage E: Travel Emergency Medical ... 17
E1 - Description of Coverage ... 17
E2 - Amount of Travel Emergency Medical ... 17
E3 - Benefits and Eligible Expenses ... 17
E3.1 Ambulance ... *17*
E3.2 Anesthetist ... *17*
E3.3 Appliances and Durable Equipment ... *17*
E3.4 Drug Therapy ... *17*
E3.5 Emergency Dental Treatment Expense ... *18*
E3.6 Family Transportation ... *18*
E3.7 Hospital ... *18*
E3.8 Hotel Convalescence Expense ... *18*
E3.9 Meals and Accommodation ... *18*
E3.10 Medical/Surgical Services ... *19*
E3.11 Nursing Care ... *19*
E3.12 Other Medical Supplies and Services ... *19*
E3.13 Paramedical ... *19*
E3.14 Physiotherapy ... *19*
E3.15 Return of Remains ... *19*
E3.16 Vehicle Return ... *19*
E4 - Travel Emergency Medical Limitations ... 20
E5 - Travel Emergency Medical Exclusions ... 20
Coverage F: Excess Medical ... 22
F1 - Description of Coverage ... 22
F2 - Amount of Excess Medical ... 22
F3 - Benefits and Eligible Expenses ... 22
F3.1 Ambulance ... *22*
F3.2 Dental Injury ... *22*
F3.3 Drug Therapy ... *23*
F3.4 Durable Equipment ... *23*
F3.5 Nursing Care ... *23*
F3.6 Paramedical ... *23*
F3.7 Semi-Private Room Costs ... *23*
F4 - Deductible ... 23
F5 - Recurrent Injury, Sickness or Disease ... 24
F6 - Exclusions, Limitations, and Special Provisions ... 25
ALLIANZ ASSIST SERVICES ... 27

Insuring Agreement

The Wawanesa Life Insurance Company hereby contracts with:

Name and Address of Policyholder:

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

Policy Effective Date:	November 1, 2012 at 12:01 A.M. standard time at the head office address of the Policyholder as stated above. It continues in force for the period for which premium has been paid.
Renewal Date	August 1, 2017 and each August 1 thereafter, subject to the terms of this policy.
Premiums Due	Payment is due on the first of each month and a period of 60 days is allowed for the payment of every premium starting on the premium due date.

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

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

Signed by The Wawanesa Life Insurance Company at its Executive Office in Winnipeg, Manitoba, Canada on the Master Policy Effective Date.

Pat Horncastle
President

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Schedule

1. **Eligible Employee Class:**

   Class I: All permanent Employees under the Age of 65 working a minimum of 15 hours per week (averaged over the latest three-month period of being Actively at Work) who have satisfied their Employer's Waiting Period.

2. **Waiting Period:** as shown on the Member Clients Enrolment Form and on file with the Administrator.

3. **Deductible:**

   Excess Medical Deductible: $2,500 per person per calendar year

4. **Grace Period for premium payment:** 60 days

5. **Non-Evidence Benefit Maximums:**

   Travel Emergency Medical .... $ 2,000,000

   Excess Medical.. $ 250,000

6. **Benefit Amounts**

   Coverage E: Travel Emergency Medical (Benefit Maximums)

Benefit	Maximum
Medical Expenses Lifetime	$ 2,000,000
Appliances and Durable Equipment	$ 2,000
Emergency Dental Treatment	$ 2,000
Hotel Convalescence	$ 1,000
Nursing Care	$ 5,000
Meals and Accommodation	$ 1,500
Paramedical	$ 300
Physiotherapy	$ 1,000
Return of Remains	$ 5,000
Vehicle Return	$ 2,000

   Coverage F: Excess Medical (Benefit Maximums)

   Lifetime Maximums

Benefit	Maximum
Benefits Lifetime, total of all expenses	$ 250,000
Benefits, total of all expenses per calendar year	$ 125,000
Benefits Lifetime, per listed expense item	$ 50,000

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Yearly Maximums

Ambulance	$	25,000
Dental Injury	$	25,000
Drug Therapy	$	25,000
Durable Equipment	$	25,000
Nursing Care	$	25,000
Paramedical	$	25,000
Semi Private Room Costs	$	25,000

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General Policy Definitions

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

(a) occurs at an identifiable time and place;

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

(c) arises from an external source to the Insured Person.

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

"Additional Insurance" *means* the Benefit Amount exceeding the non-evidence benefit maximums of each benefit.

"Administrator" *means* myHSA Ltd.

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

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

"Benefit Amount" *means* the insurance benefits provided in the policy and is the amount of insurance issued as shown on the Schedule.

"Dependent Child(ren)" *means* all unmarried children of an Insured Employee, of a Spouse or of both. This includes legally adopted children, and those children (in the case of a minor) for whom the Insured Employee or Spouse exercise (or would exercise) parental authority and whom the Insured Employee or Spouse support and who are:

(a) under Age 21; or

(b) at least Age 21, but under Age 25, and are full-time students at an accredited educational institution, subject to proof of registration to the satisfaction of the Insurer; or

(c) regardless of Age, suffering from a severe, incurable and chronic physical or mental disability while meeting the requirements indicated above of Dependent Children, rendering such children unable to pursue a substantially gainful occupation, subject to adequate medical Evidence;

and who:

(a) are covered by a Provincial Health insurance plan; and

(b) reside in Canada.

Dependent Children will be covered from birth provided such children are born alive.

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

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

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

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“Emergency” *means* sudden, unexpected and not preplanned.

“Employee” *means* a person who is under Age 65 and who is:

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

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

(c) a Canadian citizen or permanent resident of Canada; and

(d) residing in Canada.

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

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

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

“Evidence” *means* evidence deemed satisfactory by the Insurer to confirm a state or condition.

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

“Illness” *means* a Disease, mental infirmity or Sickness. Any surgery needed to donate a body part to another person, which causes Total Disability, will be considered an Illness.

“Immediate Family Member” *means* a person at least 18 years of Age, who is the son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, (all of the above include natural, adopted or step relationship), Spouse, grandson, granddaughter, grandfather or grandmother of an Insured Person.

“Injury” *means* bodily Injury to an Insured Employee caused solely by an Accident which occurs while this policy is in force. The Injury must be the basis of a claim and result directly and independently of all other losses covered by this policy, 24 hours a day, anywhere in the world. In no event shall Injury mean Sickness or Disease unless caused by an Accident.

“Insured Person” *means* collectively, an Insured Employee, an Insured Spouse or an Insured Dependent Child, if applicable, eligible for insurance under a provision of this policy, unless otherwise stated in this policy.

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

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

(b) is not experimental or investigative in nature; and

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

“Month” *means* a period starting at 12:01 A.M. on the first day in a given calendar Month, and ending at 12:01 A.M. on the first day in the next calendar Month.

“Nurse” means a graduate registered nurse (R.N.), or a Nurse who is licensed to practice nursing services by a governmental agency that has jurisdiction over such licensing. A Nurse cannot be the Insured Person nor an Immediate Family Member.

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“Physician” *means* a doctor of medicine (other than an Insured Person or Immediate Family Member) who is licensed to practice medicine by:

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

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

“Regular Care and Attendance” means observation and treatment to the extent necessary under existing standards of medical practice for the condition requiring such treatment, disability, or causing Hospital confinement.

“Residence” means both the primary dwelling in Canada of which an Insured Person is an occupant and the premises on which it is situated.

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

“Spouse” *means* an individual residing in Canada and covered by a Provincial Health insurance plan under the age of 65:

(a) to whom the Insured Employee is legally married; or

(b) with whom the Insured Employee has continuously cohabited in a conjugal relationship for a minimum of one year immediately before a loss is incurred under the policy.

Only one individual will qualify as a Spouse. If the Insured Employee is legally married but is also cohabiting with an individual as described under item (b) above, the Insured Employee may elect in writing which one of the individuals will qualify as a Spouse under the policy. This election must be filed with the Policyholder. The Insurer will not be bound by an election not filed before the event insured against. If an election is not filed, the Spouse will be the individual to whom the Insured Employee is legally married.

“Totally Disabled/Total disability” *means* an Insured Employee is prevented from engaging in every occupation or employment for compensation or profit for which he or she is, or may become, reasonably qualified by reason of education, training or experience.

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

“Trip” *means* travel which commences on the date of departure from the Insured Person’s province of Residence and continues until the return date of the Insured Person’s province of Residence, subject to a maximum duration of 60 consecutive days.

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General Policy Provisions

1 - Eligibility for Insurance

1.1 Eligibility

Class I Employees of the Employer will be eligible for insurance from the date as outlined in the Waiting Period mentioned in the Schedule.

An Employee's Dependents will be eligible for insurance on the same date as the Employee, or on a subsequent date on which they become Dependents of the Employee.

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

If two Insured Employees are Spouses of each other and are eligible for insurance under this policy, one of the two may choose to be insured as an Insured Spouse of the other, in which case they will not be considered to be an Insured Employee. Otherwise both may choose to be covered as an Insured Employee, in which case neither will be eligible as a Spouse.

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

1.2 Participation in the Insurance Plan

For Employees, Spouses, and Dependent Children eligible for an Employer's mandatory insurance, participation in the insurance plan is required.

2 - Effective Date of Individual Insurance

2.1 Employee Insurance

An Employee's insurance will become effective on the date he or she becomes eligible, on condition that an application has been received by the Administrator before such date, or within the 31 days thereafter; otherwise, coverage becomes effective on the first day of the month following acceptance of Evidence of insurability by the Insurer.

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2.2 Spouse and Dependent Children

Coverage for a Spouse and Dependent Children will become effective on the date on which they become eligible, provided the Administrator receives an application prior to such date or within 31 days following such date; otherwise, coverage becomes effective on the first day of the month following the acceptance of Evidence of insurability by the Insurer. However, following the Spouse's and Dependent Children's participation in the plan, coverage for any other Dependent Child shall automatically become effective on the date such child meets with the definition of "Dependent Child".

Coverage for a Spouse and Dependent Children can, at no time, become effective before an Insured Employee's Effective Date of Individual Insurance.

If a Dependent, other than a newborn child, is confined at home or in a Health Care Facility on the date his or her insurance would otherwise become effective, the Life Insurance will be postponed until the eighth day after the end of such confinement.

"Health Care Facility": refers to facilities such as:

(a) hospital of any kind;
(b) a skilled nursing facility;
(c) an alcoholism treatment facility;
(d) a place for treatment of drug or chemical addiction or dependence;
(e) a place for treatment of mental, nervous or emotional disorders or conditions;
(f) a place for custodial care.

2.3 Effective Hour on Effective Date

For the purposes of this policy, the Effective Date of Individual Insurance of will be the given date from 00.01 hour A.M. at the Residence of the Insured Employee, enrolment is optional and application being approved.

2.4 Actively at Work

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

3 - Change in Coverage of an Insured Person

If an occurrence takes place affecting the class of insurance or revising the coverage of an Insured Person, the Policyholder agrees to notify the Administrator, in writing, within 31 days.

If there is a benefit increase or a change in the class of insurance, then the revised coverage will become effective on the first day of the month following the date the Administrator receives notice from the Policyholder. If the notice of revised coverage is not received within the allotted time then Evidence of Insurability will be required and the revised coverage will become effective on the first day of the month following the acceptance of Evidence of insurability by the Insurer.

If there is an increase in coverage and an Insured Employee is not Actively at Work on the date when his or her class of insurance or coverage would normally be revised, the revised coverage will become effective on or after the first day of the month when the Insured Employee returns to being Actively at Work.

If there is a benefit decreases, then the revised coverage will become effective from the first day of the month following the date of the change.

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4 - Termination of Individual Insurance

4.1 Employee

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

(a) the date of the policy terminates;

(b) the date the participating group/association terminates;

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

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

(e) the premium due date following the date the Insured Employee ceases to be Actively at Work because of leave of absence, lay-off, maternity leave, disability, resignation, or dismissal, except as provided under section 5 - Continuation of Individual Coverage or section 6 - Waiver of Premium;

(f) the date on which the Waiver of Premium terminates, with respect to a benefit for which the premium is being waived under section 6 - Waiver of Premium, unless the Insured Employee has resumed payment of the premium as an Employee;

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

(h) the date the Insured Person ceases to be a Canadian resident;

(i) the date the Insured Person ceases to be covered by a Provincial Health insurance plan;

(j) the date of the Insured Employee's death;

(k) the date they reach Age 65.

4.2 Dependents

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

(a) the date the Insured Employee's insurance ceases;

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

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

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5 - Continuation of Individual Coverage

5.1 Continuation of Coverage

(a) An Insured Employee who ceases to be Actively at Work as a result of Sickness or Injury may continue to be insured while disabled until the earlier of Age 65, or until his or her employment in a class of Employees eligible for insurance terminates, or until a period of two years from the date of disability has occurred, provided that the Policyholder pays to the Insurer the premium for such Insured Employee in the usual way.

(b) An Insured Employee who is no longer Actively at Work because of unpaid leave may continue to be insured during such leave until the earlier of Age 65, or until a period of six months from the beginning of the unpaid leave has occurred, provided the Policyholder pays to the Insurer the premium for such Insured Employee in the usual way and within 31 days of the start of such leave the Policyholder informs the Administrator of the date such leave is due to end. For the purposes of this provision, suspension cases are treated in the same way as unpaid leave.

(c) An Insured Employee who ceases to be eligible for insurance on account of a temporary lay-off may continue to be insured until the earlier of Age 65, or until a period of six months from the date of layoff has occurred, provided that the Policyholder pays to the Insurer the premium for such Insured Employee in the usual way:

(1) the disability income benefits, if they are provided in the policy, will terminate on the day of the lay-off and will be reinstated on the day of the return to work in the capacity for which they are made eligible for insurance;

(2) the other benefits continue to apply in the same manner as if there had not been a temporary lay-off;

(3) the total premium is payable for the month during which the temporary lay-off begins; the total premium for the month, reduced by the part applicable to the disability income benefits, when included in the policy, is payable during the other month while the absence from work resulting from a temporary lay-off is continued. However, if the lay-off does not persist for at least seven consecutive days, the total premium for the month is payable for the month of the lay-off and for the month of return to work.

(d) An Employee who does not continue to be insured for any reason under the provisions of items (a), (b) or (c) above at the very beginning of unpaid leave or lay-off cannot do so thereafter.

(e) The Policyholder must forward to the Administrator each month a list showing the name and the policy number of Insured Employees who are on unpaid leave, suspended and laid-off and of Insured Employees who are returning to work, specifying the date in each case.

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5.2 Reinstatement of Individual Coverage

Wherever used throughout this policy, “Reinstatement” refers to this section.

(a) An Employee who has not continued to be insured for any reason under the provisions of items (a), (b) or (c) in section 5.1 Continuation of Coverage and who returns to work within the six months following the start of disability, unpaid leave, or temporary lay-off may be insured again without having to satisfy the applicable Waiting Period;

(b) An Employee whose coverage was continued under the provisions of items (a), (b) or (c) in section 5.1 Continuation of Coverage and whose coverage was subsequently discontinued for any reason prior to returning to work and prior to the expiry of the maximum period available for Continuation of Coverage, will be terminated from coverage at the end of the month in which their coverage was discontinued. If the Employee returns to work within the six months following the start of disability, unpaid leave, or temporary lay-off, the Employee may be insured again without having to satisfy the applicable Waiting Period.

Reinstatement is only available to Employees who are under Age 65.

6 - Claims

6.1 Beneficiary

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

(a) The Insured Employee’s beneficiary, for any amount of insurance payable at his or her death and subject to applicable law, will be the Insured Employee’s estate.

(b) The Insured Employee will be considered the beneficiary for all other indemnities payable, including those payable for the Insured Spouse and/or Insured Dependent Children.

6.2 Notice and Proof of Claim

An Insured Person, the Insured Person’s representative, or a Beneficiary entitled to make a claim must:

(a) give written notice of claim to the Insurer no later than 30 days after an Accident, Injury, or Illness that has caused a loss and for which expenses are incurred. Claims notices may be sent to the Insurer via fax, email, Canada Post or in-person at the Insurer’s Administrative Office; and

(b) within 90 days from the date a claim arises under the contract:

  (1) furnish satisfactory proof to the Insurer as is possible in the circumstances providing evidence of the claim and the cause; and

  (2) any other information the Insurer may reasonably require to establish the validity of the claim.

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An Insured Person, his or her representative, or a Beneficiary entitled to make a claim shall provide proof of claim within 12 months from the date a claim arises due to Travel Emergency Medical expenses, and will furnish proof satisfactory (may require original of receipts) to the Insurer of:

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

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

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

All claims are payable in legal currency of Canada to the Insured Employee or, in the case of an amount of insurance payable upon the death of the Insured Employee, to his or her appointed Beneficiary.

However, all claims respecting an unpaid account covered by an accident and sickness insurance benefit may be paid at the option of the Insurer, to the provider of the services for which the claim was submitted.

6.3 Insurer to Furnish Forms for Proof of Claim

The Insurer shall furnish forms for proof of claim within 15 days after receiving notice of claim. If the claimant has not received the forms within that time he or she may submit proof of claim in the form of a written statement with the details that gave rise to the claim.

6.4 Failure to Give Notice or Proof

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

6.5 Reserving Rights

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

(a) examine the full details regarding the claim;

(b) require an Insured Person to undergo a medical examination;

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

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

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

6.6 Fraudulent Claims

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

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6.7 Limitation of Action

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

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

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

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

6.8 Subrogation

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

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

6.9 Recovering Overpayments

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

6.10 Coordination of Coverage

Reimbursement of expenses under this policy are only payable on the excess amount of expenses after deducting the amounts which are payable to an Insured Person from any other individual or group insurance contract with a similar benefit, or any other third party or government health insurance plan. The benefits mentioned in this policy are provided as last payor coverages.

6.11 Settlement Options

A lump sum payment of any amount payable under one or several Life Insurance benefits provided under this policy, may, at the request of the Insured Employee or of the Beneficiary, be replaced by a method of payment mutually agreed upon by the Insured Employee or the Beneficiary and the Insurer such as a deposit bearing interest, guaranteed annuity, immediate or deferred life annuity.

6.12 Extension of Coverage under Previous Insurer

When a group insurance policy covering the Employees eligible for the present insurance, in effect immediately before the coming into force of this policy includes an extension of coverage, any amount payable under a benefit of this policy shall be reduced by the amount of any payment of benefits that the previous insurer is liable to make under such extension of coverage respecting a similar benefit.

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7 - Premiums

All premiums are payable in advance and according to an agreed period, at the Administrative Office of the Insurer, in legal currency of Canada.

The grace period for payment of premiums is 30 days. The insurance shall remain in force during such period provided that the premiums are paid before the expiration date of the grace period, otherwise, the policy shall be void retroactively to the due date of such premiums.

The amount of the premiums payable under this policy shall be the sum of the individual amounts payable for each Insured Employee.

The premium required for each Insured Employee does not vary during a contractual period, unless there is a change in the type of coverage or class of insurance. However, the Insurer reserves the right to change premium rates, during the contractual period when the amount or level of benefits payable or when the costs incurred by the Insurer under this policy are affected by a change or an addition to the tax systems, social security systems, a statute or a rule passed in regard to such laws or systems. Notice of such a change of premiums must be served in writing at least 30 days prior to its effective date.

The monthly premium payable for each Insured Employee will be determined in accordance with the table of costs established by the Insurer and on file with the Administrator.

The amount of the premium received by the Insurer for an Insured Employee will determine his or her class of insurance and will establish whether or not his or her Dependents are covered.

8 - Contract

8.1 Administration

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

8.2 Clerical or Mechanical Errors

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

8.3 Conformity to Legislation

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

8.4 Currency

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

8.5 Entire Contract

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

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8.6 Insurance Data

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

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

8.7 Material Facts

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

8.8 Insured Right of Access

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

8.9 Misrepresentation and Incontestability

The policy will be void and the Insurer's liability will be limited to the return of any premiums paid if incomplete, inaccurate, untrue or incorrect information was submitted to the Insurer at any time and a claim arises under the policy during the first two years from the Effective Date of Individual Insurance or two years from most recent date of Reinstatement. Misrepresentations relating to a later application for additional coverage or an increased insurance amount will void the relevant change.

8.10 Misstatement of Age

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

8.11 Non-Participating

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

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8.12 Replacement

This policy is considered a replacement policy if it replaces previous group coverage providing similar insurance benefits that the Employer terminated less than 31 days prior to the effective date of the Member Client under this policy as stated on the Member Client's Certificate.

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

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

(b) is Actively at Work on the effective date of the Member Client under this policy as stated on the Member Client's Certificate; and

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

While such Employee is not Actively at Work, each Employee and Dependent will be insured for the lesser of:

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

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

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

8.13 Renewal of Contract

This contract will be automatically renewed, unless a written notice to the contrary is given by either of the parties, according to the advance renewal notice, at least 60 days before the expiration date of the Renewal Date.

8.14 Responsibility of the Policyholder

The Policyholder agrees to forward to the Administrator the application forms of the eligible Employees applying for insurance, together with the data required to establish their class of insurance;

Upon the Insurer's request, the Policyholder also agrees to furnish the Insurer with the list of all persons eligible for insurance, whether insured or not, together with the data required to establish their class of insurance;

In the case of a collective and temporary cessation of work, the Policyholder shall provide the Administrator, without delay, with a list of the Insured Employees affected and the start date of the collective and temporary cessation of work.

8.15 Termination by the Group/Association

The participating group/association may terminate this insurance by advance written notice delivered to the Insurer at least 30 days prior to the termination date.

8.16 Termination by the Insurer

The Insurer may terminate the policy by advance written notice delivered to the Policyholder at least 30 days prior to the termination date.

8.17 Termination by the Policyholder

The Policyholder may terminate the policy on any premium due date by giving the Insurer written notice 30 days before that date.

8.18 Waiver

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

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Coverage E: Travel Emergency Medical

E1 - Description of Coverage

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

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

E2 - Amount of Travel Emergency Medical

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

E3 - Benefits and Eligible Expenses

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

E3.1 Ambulance

(a) Land ambulance to the nearest qualified medical facility;

(b) Air ambulance (including a medical attendant when necessary) that is Medically Necessary in order for the Insured Person to travel to his or her province of Residence, and if he or she cannot travel by any other means of transportation.

E3.2 Anesthetist

Expenses for the services of a licensed anesthetist when recommended by a Physician.

E3.3 Appliances and Durable Equipment

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

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

E3.4 Drug Therapy

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

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E3.5 Emergency Dental Treatment Expense

When an Injury to whole and sound teeth is caused by a force or blow external to the mouth, and the Injury requires treatment, replacement or x-rays by a legally qualified dentist or oral surgeon, then the Insurer will pay the reasonable and necessary expenses incurred by the Insured Person. The total amount of payments made will not exceed the maximum as shown in the Schedule as a result of any one Accident.

The following conditions apply:

(a) the legally qualified dentist or oral surgeon cannot ordinarily reside in the Insured Person's Residence and cannot be an Immediate Family Member of the Insured Person; and

(b) the treatment, replacement or x-rays must be performed within 30 days from the date of the Injury;

Capped or crowned teeth will, for the purposes of this policy, be considered whole and sound.

E3.6 Family Transportation

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

(a) be with the Insured Person confined in Hospital; or

(b) to identify the deceased prior to release of the body.

With respect to clause (a): in order to qualify for benefits the Insured Person must eventually be an in-patient for at least seven days outside of his or her province of Residence, plus the written verification of the attending Physician that the situation was serious enough to have required the visit.

E3.7 Hospital

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

E3.8 Hotel Convalescence Expense

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

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

E3.9 Meals and Accommodation

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

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E3.10 Medical/Surgical Services

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

E3.11 Nursing Care

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

E3.12 Other Medical Supplies and Services

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

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

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

E3.13 Paramedical

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

(a) chiropractor

(b) osteopath

(c) chiropodist or podiatrist

(d) massage therapist, on the recommendation of a Physician

(e) speech therapist

(f) psychologist

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

E3.14 Physiotherapy

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

E3.15 Return of Remains

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

E3.16 Vehicle Return

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

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E4 - Travel Emergency Medical Limitations

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

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

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

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

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

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

E5 - Travel Emergency Medical Exclusions

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

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

(b) declared or undeclared war or any acts thereof;

(c) perpetration of acts of terrorism;

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

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

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

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

(h) participation in any professional athletics;

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

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

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

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

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

(d) oral contraceptives and patent medicines;

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

(f) charges for any experimental medical treatments;

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

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

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

Travel Emergency Medical Pre-Existing Exclusion

This exclusion applies to Insured Persons who are insured under this policy within a Member Client comprised of four or less Insured Employees.

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

“Chronic Condition” means a Disease or disorder which has existed for a minimum of six Months.

“Stabilized” means there has not been a change in the medical condition requiring medical or psychiatric intervention for a minimum of six Months.

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Coverage F: Excess Medical

F1 - Description of Coverage

In accordance with the provisions of this policy, the Insurer will reimburse the reasonable and necessary charges for services or supplies received by the Insured Person within two years following the date the initial deductible under this plan is satisfied for such Eligible Expenses if an Insured Person requires medical or surgical treatment and incurs Eligible Expenses as described in Section F3 – Benefits and Eligible Expenses as a result of Injury or Illness.

F2 - Amount of Excess Medical

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

F3 - Benefits and Eligible Expenses

F3.1 Ambulance

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

F3.2 Dental Injury

When an Injury to whole and sound teeth is caused by a force or blow external to the mouth, and the Injury requires treatment, replacement or x-rays by a legally qualified dentist or oral surgeon, then the Insurer will pay the reasonable and necessary expenses incurred by the Insured Person. The total amount of payments made will not exceed the maximum as shown in the Schedule as a result of any one Accident.

The following conditions apply:

(a) the legally qualified dentist or oral surgeon cannot ordinarily reside in the Insured Person's Residence and cannot be an Immediate Family Member of the Insured Person; and
(b) the treatment, replacement or x-rays must be performed within 30 days from the date of the Injury;
(c) any payments made under this section will be in accordance with the current Fee Guide for General Practitioners published by the Dental Association in the Insured Person's province of Residence;

Capped or crowned teeth will, for the purposes of this policy, be considered whole and sound.

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F3.3 Drug Therapy

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

F3.4 Durable Equipment

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

F3.5 Nursing Care

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

F3.6 Paramedical

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

(a) chiropractor;
(b) osteopath;
(c) chiropodist or podiatrist;
(d) licensed masseur, on the recommendation of a Physician;
(e) speech therapist;
(f) licensed psychologist.

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

F3.7 Semi-Private Room Costs

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

F4 - Deductible

There is a deductible per calendar year in the amount stated in the Schedule. The deductible amount applies to all eligible expenses stated in section F3 – Benefits and Eligible Expenses as a result of Injury or Illness.

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

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F5 - Recurrent Injury, Sickness or Disease

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

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

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F6 - Exclusions, Limitations, and Special Provisions

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

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

(b) declared or undeclared war or any acts thereof;

(c) perpetration of acts of terrorism;

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

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

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

  (1) is not Medically Necessary;

  (2) is provided or required for cosmetic purposes;

  (3) is conducted as an experiment;

  (4) is provided or required for non-curative reasons; or

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

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

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

(i) operating a motorized vehicle where the Insured Person:

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

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

  (3) has refused to take a breathalyser test;

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

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

(a) expenses incurred outside of Canada;

(b) therapeutic or elective abortion;

(c) services or supplies associated with:

  (1) erectile dysfunction;

  (2) the diagnosis or treatment of infertility;

  (3) contraception;

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

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

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Exclusion for pre-existing condition(s)

This exclusion applies to Insured Persons who are insured under this policy within a Member Client comprised of four or less Insured Employees.

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

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

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ALLIANZ ASSIST SERVICES

AZGA Service Canada Inc. (hereinafter referred to as AZGA) in cooperation with Allianz Assist Services agrees to provide Allianz Assist Services to persons insured (hereinafter referred to as Member) under policy#MYH1001 issued to the Policyholder:

The following Emergency services will be provided while the Member is travelling away from his normal place of residence:

1. **24 Hour Access**: Multilingual assistance by telephone, facsimile and email services, twenty-four (24) hours a day, three hundred and sixty-five (365) days a year for Members or providers of medical services relating to the insurance protections provided or administered by the insurer.

2. **Emergency Medical Assistance**: Provide a referral to a physician, dentist or medical facility in the case of a medical emergency and will verify and confirm coverage using the insurer portal to access Member data provided by the insurer.

3. **Medical Consultation and Monitoring**: Contact the attending physician to monitor the care and services being rendered and the medical condition of the Member. AZGA will keep in frequent contact with the Member, the attending physician and the Member's personal physician and family, if necessary.

   (i) In situations where further medical treatment is required following the stabilization of the Member, every effort will be made to return the Member to Canada in order to resume treatment. The insurer, in consultation with AZGA, reserves the right to make this determination on a case-by-case basis.

   (ii) AZGA will explain to the attending physician the conditions in which the medical repatriation to Canada will take place.

4. **Medical Transportation**: Where AZGA's medical staff, in conjunction with a Member's attending physician, determine medical transportation to the nearest appropriate medical facility, or to Canada, for treatment is necessary, AZGA will arrange all aspects of the transport, including ground transport to and from the hospital and airport, at the point of departure and arrival. The medical staff of AZGA will also arrange for medical accompaniment, if necessary.

5. **Return of Deceased**: In case of the death of a Member, while travelling outside their province or territory of residence, AZGA will obtain all necessary authorizations and make arrangements for the return of the remains to the place of former residence.

6. **Legal Referrals**: AZGA will refer Members to a local legal advisor and provide assistance in arranging a cash advance from credits cards or family and/or friends to post bail and pay legal fees.

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7. **Lost Document and Ticket Replacement**: In the event of theft or loss, AZGA will provide assistance to the Member in the replacement of the necessary travel documents or tickets.

8. **Interpretation Services**: In an emergency, AZGA will provide telephone interpretation services in most major languages.

9. **Message Centre**: A Member away from home can call the AZGA operations centre and leave messages for family, friends or business associates who can contact the operations centre to retrieve them. The centre will hold such messages for fifteen (15) Business Days. In the same way, messages may be left for Members.

10. **Pre-Trip Planning**: AZGA will provide information or direct to appropriate resources on inoculation and visa requirements to Members.

11. **Visit of a Family Member**: If a Member is hospitalized outside of their province or territory of residence while travelling alone, arrangements will be made by AZGA for round-trip economy class transportation of one immediate family member (spouse, parent, child, brother or sister) of the Member from that family member's place of residence to the place where the Member is hospitalized.

12. **Trip Delay**: If a Member loses their return flight ticket due to the hospitalization of a Member travelling with them, AZGA will arrange for one-way economy class transportation to their place of departure.

13. **Return of Vehicle**: AZGA will make arrangements for the return of a Member's vehicle to the point of departure or to the nearest appropriate rental agency when necessary due to illness, injury or death of the Member.

AZGA will help the ill or injured Member to get the care needed. However, AZGA will not be responsible in any way for the availability, unavailability, quantity, quality or results of any medical services or treatment received or for the failure to obtain such services or treatment.

AZGA must be notified within 48 hours of an Emergency, or when reasonably possible, following an Emergency. Claims may be reduced if contact is not made with AZGA within 48 hours of admission to Hospital.

Telephone call service is available 24 hours a day, 365 days a year for any medical, travel or personal Emergency.

This service is available provided Policy #MYH1001 remains in force with The Wawanesa Life Insurance Company and AZGA continues to provide this service to The Wawanesa Life Insurance Company.

This program does not form part of the contract with The Wawanesa Life Insurance Company.

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