Maximum benefit®

Travel Health

FOR 24 HOUR EMERGENCY MEDICAL TRAVEL ASSISTANCE WHILE TRAVELLING CALL:

Canada and USA
1 888.440.2667 (toll free)

From Other Countries
1 416.340.1316 (call collect)

For information regarding the insurance policy please call:
Maximum Benefit – 1 800.893.7587

The Travel Health Coverage is not available should this employee, or any of their dependents, travel to a country that has a Travel Warning in effect. Current information about which countries have Travel Warnings can be accessed at www.travel.gc.ca.

IMPORTANT: In the event of an emergency hospital admission, the emergency medical travel assistance service MUST be notified within 48 hours. Failure to notify the service will limit benefits.

ADDITIONAL OUT OF COUNTRY COVERAGE

If you will be out of country for longer than your group Out of Country limit, (i.e. will be gone for 120 days and your group benefit is for 90 days), you can purchase an individual policy through Co-operators Life to cover the additional days outside the country.

Please call 1 800.379.9628, and let Co-operators Life know that you are looking to purchase an Individual policy to cover you once your group Out of Country benefits end.

SCHEDULE OF BENEFITS

Policy Holder: Johnston Group Inc.
Policy Number: 7949

This booklet contains further clauses which may limit coverage. Please read all the benefit description pages carefully. Please note that all dollar amounts are expressed in Canadian currency.

Calendar Year Deductible	Nil
Co-insurance Level	100%
Overall Maximum per Insured Person	$5,000,000 per Coverage Period
Description of Classes	Please see your Benefit Summary for further details
Work Hours Required	Please see your Benefit Summary for further details
Eligibility Period	Please see your Benefit Summary for further details
Common Law Spouse for Cohabitation Period	Please see your Benefit Summary further details
Age Limits for Dependent Children	Please see your Benefit Summary for further details
Pre-Existing Condition Stability Period – Active Employees and Retirees under age 70	None
Pre-Existing Condition Stability Period – Active Employees and Retirees	Age 70 to 79 – 6 months Age 80 to 99 – 12 months
Coverage Period	Please see your Benefit Summary for further details
Survivor Benefit	Please see your Benefit Summary for further details
Termination Age	Please see your Benefit Summary for further details

Travel health coverage is provided under the Johnston Group Inc. Emergency Out of Province/Out of Canada Group Policy. This plan covers medical emergencies that take place outside your province or country of residence. Co-operators Life, through Allianz Global Assistance, provides all emergency medical assistance services.

Hospital Accommodation	Reasonable & Customary Costs
Physician Charges	Reasonable & Customary Costs
Diagnostic Services	Reasonable & Customary Costs
Paramedical Services	$250 per eligible Profession
Prescription Drugs	30-day supply per Prescription
Ambulance Services	Reasonable & Customary Costs
Medical Appliances	Reasonable & Customary Costs
Private Duty Nurse	Up to $5,000
Out of Canada / Referral Benefit	Up to $50,000 per lifetime
Emergency Air Transportation	Reasonable & Customary Costs
Transportation to Bedside	Economy Round-trip Airfare plus up to $150 per day to $3,000
Return of Travelling Companion	One-way Airfare
Treatment of Dental Accidents	Up to $2,000
Meals and Accommodation	Up to $150 per day to $3,000 per trip
Vehicle Return	Up to $5,000
Return of Deceased	Up to $5,000
Incidental Expenses	Up to $250

ELIGIBILITY

ELIGIBILITY OF AN EMPLOYEE
An Employee is eligible for coverage under this Policy if they satisfy the eligibility criteria as indicated in the Maximum Benefit Extended Health Care plan.

ELIGIBILITY OF A DEPENDENT
Dependents are eligible for insurance on the later of:
- The date the Employee is eligible, or
- The date the person becomes a Dependent.

EFFECTIVE DATE OF AN EMPLOYEE'S INSURANCE
The insurance of an eligible Employee shall take effect on the date the Employee's coverage becomes effective as indicated in the Maximum Benefit Extended Health Care plan.

EFFECTIVE DATE OF A DEPENDENT'S INSURANCE
Insurance for a Dependent shall take effect on the date the Employee becomes insured under this Policy or the date the Dependent is insured under the Employee's Maximum Benefit Extended Health Care plan, if later.

TERMINATION OF AN EMPLOYEE'S INSURANCE
The insurance of any Employee under this Policy shall automatically terminate when coverage terminates under the Maximum Benefit Extended Health Care plan.

TERMINATION OF A DEPENDENT'S INSURANCE
Insurance with respect to a Dependent shall automatically terminate when coverage terminates under the Employee's Maximum Benefit Extended Health Care plan.

DEPENDENT SURVIVOR BENEFITS
In the event of an Employee's death, the coverage for an insured Dependent with respect to Out of Province/Out of Canada emergency coverage will continue for the number of months as indicated in the Schedule of Benefits from the date of the Employee's death, provided this Policy and the Participating Company's coverage under this Policy remains in force and the Dependent does not become eligible for benefits under any other group insurance plan as either an Employee or Dependent and the Dependent remains eligible as defined in this Policy. Premiums are required for the extension of the Dependent's coverage.

REINSTATEMENT OF AN EMPLOYEE'S INSURANCE
An Employee's insurance under this Policy will be reinstated the date the Employee's coverage is reinstated under the Maximum Benefit Extended Health Care plan.

BENEFITS

Out of Province/Country Emergency Benefits for Employees and Dependents

ASSESSMENT STANDARD

All Allowable Expenses covered under this provision must represent Reasonable and Customary Treatment of the Covered Person's Medically Diagnosed Condition.

AMOUNT PAYABLE

Co-operators Life will reimburse the Employee for Allowable Expenses:

(i) That are incurred while the Employee or Dependent is insured under this Provision; and

(ii) That exceed the deductible, for an Employee who is required to pay a deductible.

COVERED EXPENSES

Allowable Expenses are the lesser of the actual charges and the Reasonable and Customary Costs for covered services and supplies.

"Reasonable and Customary Costs" means costs that are incurred for approved, covered medical services or supplies that do not exceed the standard fee of other providers of similar standing in the same geographical area, for the same treatment of a similar Sickness or Injury.

DATE EXPENSES ARE INCURRED

For the purposes of all calculations made under this Provision, Allowable Expenses for services and supplies are considered to be incurred when the Covered Person receives them.

PRE-DETERMINATION OF ALLOWABLE EXPENSES

Co-operators Life must be contacted before a Covered Person seeks any medical treatment. If the Covered Person's Medically Diagnosed Condition renders him/her unable to do so, then someone else must contact Co-operators Life. It is the Covered Person's responsibility to ensure that Co-operators Life has been contacted prior to receiving medical treatment or as soon as reasonably possible.

If this pre-determination is not obtained, Co-operators Life's only obligation will be to reimburse the Covered Person for the claim on the basis of the recommendations that would have been made if the pre-determination request had been submitted and the Covered Person will be responsible for paying any difference between the amount actually incurred and the Reasonable and Customary Costs reimbursed by Co-operators Life.

AVAILABILITY OR QUALITY OF CARE – LIMITATION
Co-operators Life shall not take any responsibility for the availability or quality of any medical treatment (including the results thereof) or transportation at the vacation destination, or the Covered Person's failure to obtain medical treatment during the Coverage Period.

COVERED SERVICES AND SUPPLIES
To qualify for coverage the Covered Person must be covered by the Government Health Insurance Plan in the Covered Person's province of residence.

Any benefit otherwise payable under this Policy will be reduced by any amount the Covered Person received or is eligible to receive from:

(i) Any Government Health Insurance Plan, or
(ii) Worker's compensation act or any similar statute, or
(iii) Any government hospital, medical, dental or health care Plan, whether payable or not, or
iv) Any other insurance under which the Covered Person may have coverage.

Where the Government Health Insurance Plan provides a grant in lieu of actual reimbursement for medical services and supplies, Covered Persons will be deemed to have received the maximum grant available unless their "grant notification" states otherwise. The Covered Person must submit a copy of the grant notification together with all receipts to Co-operators Life.

Benefits will be payable as stated under this Policy once an amount equal to the grant has been spent on the Covered Expenses for which the grant was intended. Where payment is available under a charitable organization or other plan, it will be made as per the Co-ordination of Benefits Provision.

OUT-OF-PROVINCE/COUNTRY EMERGENCY CARE
Out-of-Province or Out-of-Country Emergency care is provided for Covered Persons under the age indicated in the Schedule of Benefits for the Coverage Period indicated in the Schedule of Benefits if:

(i) It is required as a result of a Medical Emergency arising while the Covered Person is travelling outside their province or territory of residence for vacation, business or education; and
(ii) The Covered Person is covered by the Government Health Insurance Plan in their province of residence.

A Medical Emergency or Emergency means the occurrence of

a Sickness or Injury during the Coverage Period that requires immediate Medically Necessary treatment for the relief of acute pain or suffering, other than experimental or alternative treatment, and such treatment cannot be delayed until the Covered Person returns to Canada and does not include medical attention for the monitoring of a stabilized condition.

During an Emergency (whether prior to admission or during a covered hospitalization), Co-operators Life reserves the right to:

- Transfer the Covered Person to one of Co-operators Life's preferred health care providers, and/or
- Return the Covered Person to their province or territory of residence

for the medical treatment of a Sickness and/or Injury where this poses no danger to the life or health of the Covered Person. If the Covered Person chooses to decline the transfer or return when declared medically stable by the Medical Director of Co-operators Life, the Insurer will be released from any liability for expenses incurred for such Sickness and/or Injury after the proposed date of transfer or return. Co-operators Life will make every provision for the Medically Diagnosed Condition of the Covered Person when choosing and arranging the mode of the transfer or return and, in the case of a transfer, when choosing the Approved Hospital.

Once the Covered Person is deemed medically stable to return to Canada (with or without medical escort) either in the opinion of the Medical Director of Co-operators Life 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.

Co-operators Life covers the Reasonable and Customary Costs, in excess of the coverage provided by the Covered Person's provincial Government Health Insurance Plan, for the following services and supplies when related to the initial Emergency medical treatment:

(i) Treatment by a Physician.

(ii) Diagnostic x-ray and laboratory services – laboratory tests and x-rays prescribed by the attending physician and that are part of the emergency treatment. The Policy does not cover magnetic resonance imaging (MRI), cardiac catheterization, computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies unless such services are authorized in advance by Co-operators Life.

(iii) Approved Hospital accommodation in a standard or semi-

private ward or coronary care or intensive care unit (if Medically Necessary), if the confinement begins while the Covered Person is insured under this benefit provision. If coverage terminates for any reason during the Covered Person's Approved Hospital stay, benefits continue until discharge, to a maximum of one year. In no case will expenses for In-Patient stays be covered for a period greater than 365 days per Covered Person.

(iv) Medical supplies provided during a covered hospital confinement, when approved in advance by Co-operators Life, minor appliances such as crutches, casts, splints, canes, slings, trusses, braces, walkers and/or the temporary rental of a wheelchair when prescribed by the attending Physician, obtained outside the Covered Person's province or territory of residence and deemed Medically Necessary.

(v) Paramedical services when authorized in advance by Co-operators Life, to the maximum specified in the Schedule of Benefits.

(vi) Prescription 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, except when needed to stabilize a chronic condition or a medical condition which the Covered Person had before the Trip. This benefit is limited to a 30 day supply unless the Covered Person is hospitalized.

(vii) Ambulance services, when reasonable and Medically Necessary, by a licensed ambulance company to the nearest centre where essential treatment is available.

(viii) Emergency Air Transportation when approved in advance by Co-operators Life. Air ambulance to the nearest appropriate medical facility or to a Canadian Hospital for immediate Emergency treatment. Transport on a licensed airline with an attendant (where required) to return to the Covered Person's province or territory of residence.

(ix) Dental accident treatment to the maximum indicated in the Schedule of Benefits per Covered 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 Covered Person must consult a Physician or dentist immediately following the Injury. Treatment must begin during the Coverage period and be completed prior to returning to the Covered Person's home province or territory of residence.

An accident report is required from a Physician or dentist for claims purposes.

(x) Private Duty Nurse – the professional services of a registered private nurse, when Medically Necessary and while hospitalized, to the maximum specified in the Schedule of Benefits, per Covered Person, when approved in advance by Co-operators Life.

(xi) Emergency Medical Transportation – when approved and arranged by Co-operators Life, coverage is provided for emergency medical transportation to return the Covered Person to their home province or territory for Emergency medical treatment. If the Covered Person is travelling outside Canada, coverage is also provided for the cost of emergency medical transportation to a hospital in Canada when the Covered Person is assessed as medically transportable, provided transportation has been pre-approved and arranged by Co-operators Life.

(xii) Transportation to Bedside – when approved in advance by Co-operators Life, reimbursement for a single round-trip economy airfare from Canada plus up to the amount specified in the Schedule of Benefits for the cost of meals and commercial accommodation for one of the following: spouse, parent, child, sibling or business partner, to:

- be with the Covered Person if the Covered Person was travelling alone and was hospitalized as an in-patient in an Approved Hospital for at least 3 consecutive Days outside of the Covered Person's home province or territory of residence and that the attending Physician provides written certification that the situation was serious enough to warrant the visit; or
- identify the deceased Covered Person prior to the release of the body, where necessary.

Co-operators Life will only reimburse covered expenses evidenced by original receipts.

(xiii) Return Transportation for Travelling Companion – If the Covered Person is returned to their home province or territory of residence under the Medical Emergency Transportation benefit or the Return of Deceased benefit, Co-operators Life will reimburse the cost of a single one-way economy airfare for a travelling companion to return to Canada, when approved in advance by Co-operators Life.

(xiv) Meals and Accommodation – to the maximum specified in

the Schedule of Benefits per Covered Person, for the cost of commercial accommodation and meals for the Covered Person and/or any of their Dependents when their trip is extended beyond the last day of the scheduled Trip due to the Sickness and/or Injury suffered by the Covered Person. This benefit must be authorized in advance by Co-operators Life. The fact that the Covered Person is unable to travel must be certified by the attending Physician and supported with original receipts from commercial organizations.

(xv) Vehicle Return – to the maximum specified in the Schedule of Benefits if neither the Covered Person nor someone travelling with the Covered Person is able to operate the Covered 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 Covered Person's home province or territory of residence to the nearest appropriate rental agency. Benefits will only be payable for a single person to return the vehicle when approved and/or arranged in advance by Co-operators Life. This benefit does not cover wages lost by the person driving the Vehicle. Co-operators Life will only reimburse covered expenses evidenced by original receipts.

(xvi) Return of Deceased – to the maximum specified in the Schedule of Benefits towards the cost of preparation and transportation of the deceased Covered Person to their province or territory of residence in the event of death due to Sickness and/or Injury. In the case of cremation and/or burial at the place of death of the Covered Person, this benefit is limited to $2,500. The cost of the casket or urn is not covered.

(xvii) Incidental Expenses – to the maximum indicated in the Schedule of Benefits for the Covered Person's out-of-pocket expenses such as telephone charges, television rental and parking while the Covered Person is hospitalized for an Emergency and the expenses are incurred as a direct result of such hospitalization. Co-operators Life will only reimburse covered expenses evidenced by original receipts.

OUT OF CANADA REFERRAL BENEFIT

Referral out of Province of residence or Canada for medical treatment which is unavailable in Canada, up to the Out-of-Province/Canada Referral maximum indicated in the Schedule of Benefits. The purpose of this benefit is not intended to be a relief from treatment waiting lists or to expedite treatment otherwise available in Canada or the Covered Person's Province of residence.

For Referred treatment given outside the Province of residence/

Canada, Co-operators Life:

- Requires that it be recommended as necessary by a Physician practicing in Canada, and
- Requires that the Covered Person be covered by the Government Health Insurance Plan in their Province of residence, and
- Treatment be approved and covered in whole or part by the Covered Person's Government Health Insurance Plan in their Province of residence, and
- That a detailed treatment plan be submitted with cost estimates before treatment begins.

Co-operators Life will then advise the Employee of any benefit that will be provided.

Co-operators Life covers the Reasonable and Customary Charges, in excess of the coverage provided by the Covered Person's provincial Government Health Insurance Plan, or which would have been payable had proper application been made, for the following services and supplies when related to the referred medical treatment:

- Physicians Services;
- Hospital room and board at standard Ward rates;
- The cost of Hospital Services;
- Hospital charges for out patient treatment;
- Licensed ambulance services, including air ambulance to transfer the patient to the nearest medical facility or Hospital where adequate treatment is available; and
- Medical evacuation for admission to a hospital or medical facility in the province where the patient normally resides.

All other charges incurred while outside the province of residence are payable under the appropriate covered Expense on the same basis as if they were incurred in the province of residence.

GENERAL LIMITATIONS AND EXCLUSIONS

No benefits will be paid for:

1. Expenses that private insurers are not permitted to cover by law.
2. Services or supplies payable by worker's compensation or similar statute or a Third Party or where the Covered Person is entitled to without charge or for which a charge is made only because the Covered Person has insurance coverage.
3. Services or supplies that do not represent Reasonable and Customary Treatment of the Covered Person's Medically Diagnosed Condition.
4. Services or supplies associated with:

- treatment performed for cosmetic purposes only;
- recreation or sports rather than with other regular daily living activities;
- services or supplies in connection with a change in gender;
- anti-obesity treatment, including drugs, protein and dietary or food supplements whether or not prescribed for a medical reason;
- the diagnosis or treatment of infertility; or
- contraception, other than contraceptive drugs.

5. Services or supplies:
   - not specifically listed as a covered expense; or
   - associated with covered items, unless specifically listed as a covered expense.
6. Services or supplies received outside Canada except as specifically listed as covered under the Emergency Out-of-Province or Canada provision.
7. Expenses incurred for:
   - the completion of claim forms;
   - obtaining further medical information regarding claims for covered expenses;
   - medical screening or examinations for the use of a Third Party, or
   - broken appointments, travel expenses or communication costs by a Medical Practitioner.
8. Expenses arising from:
   - war, revolution or military power, insurrection, civil commotion, acts of terrorism or voluntary participation in a riot, or
   - active duty as a member of any branch of the armed forces of any government.
9. Extra charges which may result due to the Medical Practitioner or any other health practitioner opting-out of the provincial Government Health Insurance Plan. Coverage will be provided on the same basis as if the Medical Practitioner or any other health practitioner was a member of the provincial Government Health Insurance Plan.
10. Medical Care or expenses which are provided or covered by a Government Health Insurance Plan, a Third Party, any worker's compensation act or similar statute or a charitable organization, even if the Covered Person has opted-out of the Plan.
11. Medical Care that was necessitated either wholly or partly, directly or indirectly as the result of committing, attempting or provoking an assault or criminal offence.
12. Medical Expenses incurred as a result of a situation from Injuries

sustained in, or directly or indirectly from, a Vehicle accident where the Covered Person was driving a Vehicle involved in the accident and had either:

- alcohol in his or her blood in excess of 80 milligrams of alcohol per hundred milliliters of blood; or
- his or her capacity impaired as a result of drug or alcohol usage.

13. Treatment or services normally covered or reimbursable under a Government Health Insurance Plan or under other insurance the Covered Person might have.
14. Any condition that existed prior to departure unless such pre-existing medical condition has been stable (i.e. no change in symptoms, no hospitalization, no change in condition, no new prescription drugs or prescribed change in treatment or medication) immediately prior to departure for the Pre-existing Condition Stability Period specified in the Schedule of Benefits.
15. Any Trip booked or commenced contrary to medical advice or after being diagnosed with a Terminal Illness.
16. Any medical condition for which, prior to departure, medical evidence suggests a reasonable expectation that treatment or hospitalization could be required while travelling.
17. Treatment, surgery, medication, services or supplies that are not required for the immediate relief of acute pain and suffering or that the Covered Person elects to have provided outside his province or territory of residence when medical evidence indicates that the Covered 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.
18. 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. This exclusion does not apply to the Out of Canada Referral Benefit.
19. Cardiac catheterization, angioplasty, and/or cardiovascular surgery including any associated diagnostic test(s) or charges unless approved by Co-operators Life prior to being performed, except in extreme circumstances where such surgery is performed on an Emergency basis immediately upon admission to Hospital.
20. Magnetic resonance imaging (MRI), computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies

unless such services are authorized in advance by Co-operators Life.

21. Hospitalization or services rendered in connection with general health examinations for “check-up” purposes, treatment of an Ongoing Condition, regular care of a chronic condition, home health care, investigative testing, rehabilitation or ongoing care or treatment in connection with drug, alcohol or any other substance abuse or non-compliance with any prescribed medical therapy or treatment and medical treatment of an acute Sickness and/or Injury after the initial Emergency has ended (as determined by the Medical Director of Co-operators Life).
22. A disorder, disease, condition or symptom that is emotional, psychological or mental in nature unless the Covered Person is hospitalized.
23. Emergency air transportation and/or car rental, unless approved and arranged in advance by Co-operators Life.
24. Treatment not performed by or under the supervision of a Physician or licensed Dentist.
25. Treatment or hospitalization of mother or child as a result of pregnancy, miscarriage, childbirth or complications of any of these conditions occurring in the 4 weeks before or after the expected delivery date.
26. Terrorism or by any activity or decision of a government agency or any other entity to prevent, respond to or terminate terrorism except for ensuing loss or damage which results directly from fire or explosion. Such loss or damage is excluded regardless of any other cause or event that contributes concurrently or in any sequence to the loss or damage.
27. Suicide (including any attempt thereat) or self-inflicted injury, whether or not the Covered Person is sane.
28. Participation in any sport as a professional athlete (for which the Covered Person is remunerated), or in motorized or mechanically assisted racing or speed contests (defined as an organized activity of a competitive nature in which speed is a determining factor in the outcome of the event).
29. Loss or damage to hearing devices, eyeglasses, sunglasses, contact lenses, or prosthetic teeth, limbs or devices and resulting prescription thereof.
30. The replacement of an existing prescription whether by reason of loss, unless otherwise specified elsewhere in this policy,

renewal or inadequate supply or the purchase of drugs and medications (including vitamins) which are commonly available without a prescription or which are not legally registered and approved in Canada or which are not required as a result of an Emergency.

31. Upgrading charges and cancellation penalties for airline tickets, unless approved in advance by Co-operators Life.
32. The cost of any airline ticket covered under this policy where the Covered Person's ticket may be exchanged or used for the same purpose.
33. Crowns and root canals.
34. Treatment or services received in the province where a Covered Person attends school or works on a full-time basis or in his home country, if such Covered Person is a foreign student studying in Canada or a non-resident working in Canada.

CLAIMS

PROOF OF CLAIM

To be entitled to payment of benefits provided under this Policy, the Covered Person, on their own behalf and on behalf of his Dependents hereby authorizes any Physician, health professional, hospital, institution and any other organization to forward to Co-operators Life or its representatives, all information, reports or documents that they may require.

The Covered Person hereby authorizes the Insurer to communicate directly with any Physician, health professional, hospital, institution or other organization to obtain any information required for the assessment of claims and hereby relieves the persons concerned of all legal responsibility which could arise from the disclosure of such information.

Each Employee is required to prove their entitlement to benefits under this Policy and to provide notice of claim in accordance with this Policy. Any expenses incurred will be the Employee's responsibility.

CLAIM FORM

An Employee must submit a claim for benefits under this Policy on the Insurance Company's claim form (the "Claim Form") provided to the Employee by Maximum Benefit or the Participating Company, at the time of claim. The Claim Form shall be completed by the Employee, the Participating Company and where necessary, a Physician.

TIME TO SUBMIT CLAIM

Emergency Out-of-Province/Canada Claims

- In the event of a claim for Emergency services received out of province in Canada or out of Canada, the Covered Person must notify Co-operators Life immediately, failure to do so will limit the benefits payable under this Policy.
- If the Covered Person incurs any expenses without prior approval by Co-operators Life, such expenses will be covered except where the Policy expressly requires the prior approval or authorization of Co-operators Life, on the basis of Reasonable and Customary Costs that would have been payable for such expenses by the Insurer in accordance with the terms and conditions of the Policy. Such expenses may be higher than this amount; therefore the Covered Person will be responsible for paying any difference between the amount the Covered Person incurred and the Reasonable and Customary Costs reimbursed by the Insurer.

- In the event that Co-operators Life is not contacted immediately, the Covered Person, or a beneficiary entitled to make a claim, or the agent of any of them, shall:
  - give written notice of claim by delivery thereof or by sending it by registered mail to Co-operators Life not later than 30 Days from the date the claim arises under the Policy,
  - within 90 Days from the date a claim arises under the Policy, furnish Co-operators Life such proof of claim as is reasonably possible in the circumstances of the Medical Emergency.

FAILURE TO SUBMIT CLAIM OR PROOF OF ONGOING CLAIM – NO BENEFITS PAYABLE

The Employee will not be entitled to any Benefits where:

- In the case of Emergency out of province or out of Canada expenses, the Employee submits a Claim Form or any other Proof of Claim more than 12 months after the services or supplies are provided.
- If this Policy terminates, or the Participating Company's coverage under this Policy terminates, the Employee must submit claims incurred prior to the termination date no later than 90 Days after the termination date.

Proof Within A Reasonable Period

Whenever Co-operators Life requests information necessary for the initial adjudication and/or ongoing adjudication or approval of benefits or authorization on any claims, it must be submitted within the time period specified in the Insurance Company's letter of request. If not submitted in this time, Co-operators Life will not be liable to pay benefits.

LIMITATION OF ACTION

No action or proceeding at law or in equity shall be brought against Co-operators Life to recover benefits payable under this Policy:

(i) Prior to the expiration of 60 Days after the Claim Form has been filed in accordance with the requirements of this Policy; or

(ii) Unless brought:
- Where no benefits have been paid to the Employee, within one year from the expiration of the time within which the Claim Form is first required (Claims Provisions – Time to Submit a Claim) by the Policy or from the date on which Co-operators Life first denies the claim for benefits, whichever first occurs; or
- Where benefits have been paid under the Provision under which benefits are being claimed, within one year of the date on which Co-operators Life terminates the payment of benefits under the said Provision.

The time limit within which to commence an action shall expire on the date(s) as specifically provided for in this provision and in no event shall it be extended to each and every monthly payment accruing after the date(s).

CO-ORDINATION OF BENEFITS

Co-operators Life will co-ordinate benefits payable under this Policy with other Plans which also cover an insured person for similar benefits.

If an Employee or Dependent who is covered for Extended Health Care benefits and/or Out of Province/Canada benefits under this Policy is also covered under any other Plan which provides similar benefits, the amount of benefits payable under this Policy for Allowable Expenses incurred during any benefit year shall be co-ordinated and/or reduced so that the benefits payable from all Plans shall not exceed 100% of the actual Allowable Expenses.

Plans Co-ordinated with this Policy

For the purpose of co-ordination of benefits, Plan means:

- Group insurance programs;
- Any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, including any pre-payment coverage, capitation plan, franchise plan or services plan; and
- Individual travel insurance plans.

When reimbursement is available under any government plan, each covered expense is reduced by the amount payable under that plan. The reduced covered expense is then considered to be the covered expense under all other co-ordination provisions. It is subject to any applicable deductible, co-insurance or co-payment level, and maximum under this Policy. Government plans are plans that are legislated, funded, or administered by a government.

The amount payable is reduced when this Policy is secondary to another group plan. The reduction is the amount by which total payments under all group plans would exceed eligible Allowable Expenses. An eligible Allowable Expense is that portion of a customary charge for Reasonable and Customary Treatment for which coverage is provided under this Policy.

When payments are reduced, each benefit is reduced proportionately. Only the reduced benefit amount is applied to any payment maximum. Group plans are plans that are available only to Employees or a member of a particular group and not to the general public.

Student accident plans are not considered group plans. A secondary plan is one that determines its benefits after another plan.

Order of Benefit Payment

1. The Plan with no Co-ordination of Benefits provision in the Policy or Plan document is deemed to pay its benefits first (primary carrier).
2. If all Plans have a Co-ordination of Benefits provision, the following rules are applied to determine the Order of Benefit Payment. The rules depend on the basis on which the person is covered in the Plan.

A plan determines its benefits first if it covers the person as an Employee:

If the person is covered as an Employee under more than one plan, the plans are prioritized in the following order:

(i) The plan covering the person as an Active, full-time Employee;
(ii) The plan covering the person as an Active, part-time Employee;
(iii) The plan covering the person as a retiree.

A plan is secondary if it covers the person as a Dependent:

If the Covered Person is covered as a Dependent of more than one person, the plans are prioritized in the following order:

(i) The plan covering the person as a Dependent Spouse;
(ii) The plan covering the person as a Dependent Child of the parent with the earlier birthday in the calendar year;
(iii) The plan covering the person as a Dependent Child of the parent whose first name begins with the earlier letter in the alphabet, if both parents have the same birthday.

If the parents are separated or divorced:

The plans under which benefits for the child are determined are prioritized in the following order:

(i) The plan of the parent with custody of the child;
(ii) The plan of the spouse of the parent with custody of the child;
(iii) The plan of the parent without custody of the child;
(iv) The plan of the spouse of the parent without custody of the child.

Dental Accidents

In case of dental accidents, dental plans are secondary to Extended Health Care Plans with dental accident coverage.

Out-of-Country/Province Health Care Expenses

Where a person is also covered under more than one policy (for example, from employment related group insurance policy, individual or group travel or health policies, credit card coverage or any other private insurance sources) coverage will be co-ordinated with other policies according to the Co-ordinating Coverage Guidelines for Out-of-Country/Province Health Care Expenses provided by the Canadian Life and Health Insurance Association.

Capitation Plans

If other coverage is available under a capitation plan, (a pre-paid plan) benefits will be co-ordinated according to guidelines prepared by the Canadian Life and Health Insurance Association.

General Information

If benefits have already been paid under another group plan, this Policy is automatically secondary.

If these rules do not establish an order of benefit determination, or another plan has different rules, benefits will be prorated between plans in proportion to the amounts available before co-ordination.

Co-ordination of benefits will also take place within this Policy if a person is covered as both a Employee and a Dependent under this Policy; or a person is covered as a dependent of two Employees under this Policy.

Other Sources

The amount payable is also reduced when this Policy is secondary to sources other than governments and group plans. The reduction is the amount by which total payments from all sources would exceed covered expenses. When payments are reduced, each benefit is reduced proportionately. Only the reduced benefit amount is applied to any payment maximum. This plan is considered secondary only if payment has already been made by the other source.

Right of Recovery

Whenever payments have been made by Co-operators Life with respect to Allowable Expenses in a total amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Provision, Co-operators Life shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as Co-operators Life shall determine:

(i) Any persons to whom the payments were made, or
(ii) Any persons for whom the payments were made, or
(iii) Any other Insurance Companies, or
(iv) Any other organizations.

THIRD PARTY LIABILITY

Notwithstanding any other Provision in this Policy where either:

(i) An Employee becomes Totally Disabled as a result of an Injury or Sickness, or

(ii) A Covered Person becomes eligible for reimbursement of insured medical or dental expenses as a result of Injury or Sickness, for which a Third Party is or may be, directly or indirectly, either in whole or in part, legally liable, then Co-operators Life will have no obligation to pay the Employee or the Covered Persons any Benefits under this Policy, other than in accordance with this Provision.

Co-operators Life will pay Benefits under the Policy subject to the following conditions:

(i) That the Employee or Covered Person repays to Co-operators Life the full amount of the Recoverable Benefits paid or to be paid under this Policy; and

(ii) The Employee or Covered Person enters into a Reimbursement Agreement on the terms and conditions stipulated by Co-operators Life; and

(iii) The Employee or Covered Person, as the case may be, takes all steps necessary to recover from the Third Party the loss of income and/or expenses advanced or to be advanced or reimbursed under this Policy and any other expenses covered under the Third Party Benefits, including without limitation, commencing and prosecuting an action against the Third Party and if required by Co-operators Life assigning the right to any damages awarded or funds received by way of settlement from the Third Party to Co-operators Life as security for any benefits paid under this Policy.

"Recoverable Benefits" means any Benefits which are paid under this Policy as a consequence of an Injury or Sickness for which a Third Party is, or may be, directly or indirectly, either in whole or in part, legally liable.

Consequences of Failure to Obtain Consent

The Employee or Dependent must obtain the written consent of Co-operators Life before compromising or settling the action or cause of action, required in the Third Party Liability section, with the Third Party. Failure to obtain the consent of Co-operators Life will disentitle the Employee or Dependent to future Benefits under this Policy and will relieve Co-operators Life of all of its obligations to the Employee or Dependent under this Policy. Consent shall not be unreasonably withheld by Co-operators Life.

AGE
Co-operators Life shall be entitled to proof of the age of a Covered Person before making payment of any claim under this Policy.

ASSIGNMENT
The benefits payable under this Policy are assignable only to the Service Provider.

PAYEE
Benefits payable under this Policy are payable to the Employee or, when authorized, the Service Provider.

DUTY TO DISCLOSE
If Co-operators Life or the Third Party Administrator requests health evidence of insurability, the Employee or Dependent must disclose at the time of application, every fact that the Employee or Dependent is aware of that may be material to the insurance applied for under this Policy in:
- the health evidence application for insurance, and
- any medical examination, and
- any written statement or answers given as evidence of insurability.

FAILURE TO DISCLOSE
The entire coverage under this policy shall be voidable if the Insurer determines, whether before or after loss, that the Policyholder or the Covered Person has concealed, misrepresented or failed to disclose any material fact or circumstance concerning this policy or his interest therein, or if the Policyholder or the Covered Person refuses to disclose information or to permit the use of such information, pertaining to any of the Covered Persons under this policy. Consequently and following a loss, no claim shall be payable by the Insurer and the Covered Person shall be solely responsible for all expenses relating to his claim, including medical repatriation costs. Co-operators Life may contest the validity of the insurance coverage of a Covered Person if Co-operators Life learns of any failure to disclose, or any misrepresentation of fact, before the insurance for that Covered Person has been in force continuously for 2 years during the Covered Person's lifetime.

EXCEPTION TO TWO-YEAR LIMITATION
Notwithstanding the Failure to Disclose provision, where the Covered Person makes a claim for benefits under this Policy from a Sickness which began, or an Injury which occurred, before the insurance of the Covered Person under this Policy has been in force for 2 years then Co-operators Life may contest the validity of the insurance at anytime.

DEFINITIONS

“Actively At Work”, **“Actively Employed”**, **“Active Work”** or **“Actively Working”** means with respect to an Employee, a person who is considered Actively at Work as defined under the Employee’s Maximum Benefit Extended Health Care plan.

“Accident” means a fortuitous, sudden, unforeseen and unintentional event exclusively attributable to an external cause resulting in bodily Injury.

“Acute Care” shall mean active intervention required to diagnose or manage a condition that would otherwise deteriorate.

“Allowable Expenses” means only the services and supplies actually incurred by a Covered Person for treatment of a Medically Diagnosed Condition.

“Approved Hospital” is an institution designated by applicable legislation as a hospital and which fully meets every one of the following conditions:

- is legally licensed as a hospital where such licensing laws exist; and
- in Canada, is approved by the Province or Territory in which it is situated to provide insured hospital services in accordance with the Government Health Insurance Plan of the Province or Territory; where the hospital is located; and
- has medical, surgical and diagnostic facilities on the premises; and
- is open 24 hours per day and has a staff of one or more Physicians available at all times; and
- continuously provides 24 hour medical care by or under the supervision of resident professional Registered Nurses; and
- provides Acute, Convalescent, or Palliative Care.

“Approved Leave” is a temporary leave of absence approved by the Participating Company. Coverage can continue during an approved leave as long as the Covered Person remains covered under the Participating Company’s basic group extended health care plan, provided premiums are paid.

“Auto Plan Benefits” means any benefits to replace income which are payable to an Employee as a result of a motor Vehicle accident, whether payable by a:

- government run plan, or
- private insurer, and
- includes without limitation benefits which the Employee has received or is entitled to receive under any provincial motor vehicle accident insurance plan and further specifically includes no-fault benefits payable under the Manitoba Public Insurance Corporation Act, the Saskatchewan Automobile Accident Insurance Act and the Automobile Insurance Act (Quebec) or any legislation which replaces any of the foregoing, provided that benefits payable under the Employment Insurance Act are not taken into account when determining the amount of benefits payable under the provincial motor vehicle accident plan.

“Birth” means the complete expulsion or extraction from the mother of a fetus, irrespective of the duration of pregnancy, which, after complete separation from its mother, breathes or shows any sign of life.

“Convalescent Care” shall mean active treatment or rehabilitation for a condition that will significantly improve as a result of convalescent care and that immediately follows 3 or more days of confinement in an Approved Hospital for Acute Care.

“Convalescent Hospital” is an institution (or a distinct part of an Acute Care hospital or Physical Rehabilitation Centre providing Convalescent Care) which:

- has a transfer arrangement with one or more hospitals and which is regularly engaged in providing, for compensation on an in-patient basis, skilled nursing care during the convalescent or physical rehabilitative stage of an Injury or Sickness;
- charges for ward care for the Covered Person involved are covered by the Government Health Insurance Plan. In no event shall the term Convalescent Hospital include any institution or part thereof which is used principally as a rest facility, a facility for the aged or a facility for Chronic Care.

“Coverage Period” means the number of consecutive days, as stated on your Certificate of Insurance. The coverage period is calculated as of the commencement date of the Trip.

“Covered Person” is an eligible Employee or Dependent as defined under the Maximum Benefit Extended Health Care plan.

“Days” or **“Day”** means calendar days.

“Dentist” is a person who is legally licensed to practice dentistry in the Province or Territory or other jurisdiction in which the person is practicing.

“Denturist” is a person who is legally licensed to provide full denture service directly to a patient in the Province or Territory or other jurisdiction in which the person is practicing.

“Dependent” shall mean an eligible Spouse or eligible Child of the Employee as defined under the Maximum Benefit Extended Health Care plan.

“Emergency” a Medical Emergency or Emergency means the occurrence of a sudden, unexpected Sickness or Injury during the Coverage Period that requires immediate Medically Necessary treatment for the relief of acute pain or suffering, other than experimental or alternative treatment, and such treatment cannot be delayed until the Covered Person returns to Canada and does not include medical attention for the monitoring of a stabilized condition.

“Employee” is a person who is eligible for coverage under this Policy in accordance with the definition of an Employee under the Maximum Benefit Extended Health Care plan.

“Fee” means the charges as set out in the Provincial Fee Guide for general practitioners as approved and published by the Provincial Dental Association in the Province or Territory in which the Employee resides or the charge for services rendered by a Denturist as stated in the Schedule of Fees published by the appropriate organizations in the Province or Territory in which the Employee resides.

“Government Health Insurance Plan” is the Provincial, Territorial or Federal legislation and the regulations pursuant to such legislation, as amended from time to time, which provide government sponsored Hospital, Drug, Dental or other Medical Care Benefits for residents of Canada, including but not limited to: provincial Dental Care Plans, provincial Health Insurance Plans, provincial Hospital Insurance Plans, provincial drug plans, provincial Medicare Plans, federal or provincial Medical or Dental Care and Services Acts, and the Hospital Insurance and Diagnostic Services Act (Canada).

“Government Plan Benefits” are any benefits which, as a result of Injury or Sickness, are payable to an Employee from any government agency and includes without limitation any benefits which the Employee has received or is entitled to receive under the Canada Pension Plan, Quebec Pension Plan (excluding any dependent benefits and cost of living increases), and/or any worker’s compensation act or similar statute.

“Injury” shall mean an unexpected and unforeseen harm to the body that is caused by an Accident, sustained by a Covered Person during the Coverage Period and that requires emergency treatment that is covered under this Policy.

“In-patient” means a patient who occupies an Approved Hospital bed for more than 24 hours for medical treatment and for which admission was recommended by a Physician when Medically Necessary.

“Immediate Family Member” means the spouse, child, parent, sibling, stepchild, stepparent, parent of spouse, child’s spouse, sibling-in-law, grandchild, grandparent of the Covered Person.

“Maternity Leave” is the period of time allowed under the applicable Provincial Labour Standards Act or such period as agreed to by the Employee and the Participating Company, commencing on the date as agreed to by the Employee and Participating Company, or the date of delivery, whichever is earlier.

“Medical Assessment” shall mean independent medical examinations, assessments or tests performed by one or more Medical Practitioners and includes without limitation psychological assessments, neuro-psychological evaluations utilizing a generally accepted classification system, physiological examinations, and functional capacity assessments, psychometric assessments and neuro-psychological testing.

“Medical Care” shall mean Medically Necessary services, supplies or surgery, including hospitalization, provided, or ordered, by a Physician in the treatment of a Covered Person’s Sickness or Injury.

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

- is appropriate and consistent with the diagnosis according to accepted community standards of medical practice;
- is not experimental or investigative in nature;
- cannot be omitted without adversely affecting the Medically Diagnosed Condition of the covered Person or quality of Medical care;
- cannot be delayed until the Covered Person returns to their province or territory of residence.

“Medical Practitioner” includes a Physician, Specialist, Psychiatrist, Psychologist, Physiotherapist and Occupational Therapist. The Physician, Specialist and Psychiatrist must be legally licensed to practice medicine in the Province or Territory where the service is rendered and be registered by the College of Physicians and Surgeons in the Province or Territory in which the person is practicing. The Psychologist, Physiotherapist and Occupational Therapist must be licensed, certified or registered to practice the profession by the appropriate authority or the Province or Territory in which care or services are rendered, or where no such authority exists, having a certificate of competency from the professional body which establishes standards of competency and conduct for such profession. The Medical Practitioner cannot be related to the Employee.

“Medically Diagnosed Condition” or **“Medically Diagnosed”** shall mean a Sickness or an Injury which has been diagnosed according to a generally accepted classification system, including but not limited to, an x-ray, MRI, bone scan, biopsy, CT Scan, psychometric testing including MMPI-2, or a haematological or ultrasonic test.

“Ongoing Condition” means an Acute Medically Diagnosed Condition that requires continuing care and/or treatment after the initial Emergency has ended, as determined by the Insurance Company’s Medical Director.

“Palliative Care” shall mean treatment for the relief of pain in the final stages of a terminal condition.

“Parental Leave” is the period of time allowed under the applicable Provincial Labour Standards Act, commencing on the date as agreed to by the Employee and Participating Company, or the date immediately following the completion of Maternity Leave, whichever first occurs.

“Participating Company” shall mean a Company who has agreed to participate in the Maximum Benefit Extended Health Care plan and whose participation has been approved by the Third Party Administrator acting on behalf of the Insurance Company.

“Participating Company’s approved application” shall mean the signed application filed with the Third Party Administrator summarizing the Company’s applicable benefits as specified in this Policy and under the Company’s group benefit plan.

“Physician” means a medical practitioner whose legal and professional standing within their jurisdiction is equivalent to that of a doctor of medicine (M.D.) licensed in Canada, who is duly licensed in the jurisdiction in which they practice, who prescribes drugs and/or performs surgery and who gives medial care within the scope of their licensed authority. The Physician cannot be the Covered Person or related to the Covered Person.

“Practitioner” shall mean a person who is a member of a paramedical profession and is duly licensed, certified or registered to practice that profession in the Province or Territory in which the person is practicing. Licensed, certified or registered means licensed, certified or registered to practice the profession by the appropriate authority in the Province or Territory in which care or services are rendered, or where no such authority exists, having a certificate of competency from the professional body which establishes standards of competency and conduct for such profession. The Medical Practitioner cannot be related to the Employee.

“Pre-existing Condition” shall mean any existing medical condition prior to departure.

“Pre-existing Condition Stability Period” shall mean the period of time indicated in the Schedule of Benefits, immediately prior to departure, during which any Pre-Existing Condition must remain stable (ie. no change in symptoms, no hospitalization, no change in condition, no new prescription drugs or prescribed change in treatment of medication).

“Previous Policy” shall mean the Group Policy issued to the Policyholder or Participating Company by any Insurance Company which provided benefits comparable to this Policy and which was terminated, and less than 31 Days later, replaced by this Policy.

“Province” or **“the Province”** shall mean the Covered Person’s province or territory of residence.

“Reasonable and Customary Costs” means costs that are incurred for approved, covered medical services or supplies that do not exceed the standard fee of other providers of similar standing in the same geographical area, for the same treatment of a similar Illness or Sickness.

“Reasonable and Customary Treatment” shall mean systematic treatment that is:

- generally accepted and recognized by the Canadian medical profession as effective appropriate and essential in the treatment of the Medically Diagnosed Condition, and
- of a nature, intensity, frequency and duration essential to the diagnosis or management of the Medically Diagnosed Condition involved; and
- prescribed and rendered by a Physician, or where considered appropriate by Co-operators Life for the nature of the Medically Diagnosed Condition, the treatment must be prescribed and rendered by a Specialist.

“Sickness” shall mean disease or illness that results in loss while this coverage is in effect. The Sickness must be sufficiently serious to prompt a reasonably prudent person to consult a Physician for the purpose of medial treatment.

“Specialist” shall mean a Physician who specializes in a particular study or work and is registered by the College of Physicians and Surgeons in the Province or Territory in which the person is practicing and has been recognized with a designation in their area of specialty. The Specialist cannot be related to the Employee.

“Terminal Illness” means the Covered Person has a condition that is cause for the Physician to estimate that the Covered Person has less than 6 months to live.

“Termination Age” means the age stated in the Participating Company’s application at which the Employee’s coverage terminates. Dependents beyond the Termination Age may be covered provided that the Employee has not yet reached the Termination Age.

“Terrorism” means an ideologically motivated unlawful act or acts, including but not limited to the use of violence or force or threat of violence or force, committed by or on behalf of any groups, organization(s) or government(s) for the purpose of influencing any government and/or instilling fear in the public or a section of the public.

“Third Party Administrator” is Johnston Group Inc.

“Third Party Benefits” means all benefits paid or to be paid under this Policy to a Covered Person or on behalf of a Covered Person to another Party.

“Trip” means a journey undertaken by a Covered Person which commences on the date of departure from their province or territory of residence and ends when he/she returns to their province or territory of residence. If an Employee’s Dependent attends school outside of Canada, the trip duration will be extended to allow for the length of time the Dependent is actually attending school. It will also allow for up to 1 week of travel time to and from home and school. However, coverage is not extended for any additional travel more than one week before school commences or one week after it is completed. The Dependent must be covered under the Government Health Insurance Plan in order to be eligible for Out of Country coverage under this policy.

“Vehicle” means a vehicle that is drawn, propelled or driven by any means other than muscular power and, without limiting the generality of the foregoing, specifically includes a boat and a snowmobile.

FOR 24 HOUR EMERGENCY MEDICAL TRAVEL ASSISTANCE WHILE TRAVELLING CALL:

Canada and USA
1 888.440.2667 (toll free)

From Other Countries
1 416.340.1316 (call collect)

For information regarding the insurance policy please call:
Maximum Benefit – 1 800.893.7587

1051 King Edward Street, Winnipeg, MB R3H 0R4
TF: 1 800.893.7587 | TF Fax: 1 877.526.2515
In Winnipeg P: 204.774.6677 | F: 204.774.6698

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