GLOBAL MEDICAL CARE™

Best Doctors®
CANADA INSURANCE SERVICES INC

MASTER POLICY
Corporate Plan

Groupbenefitz Exec

Executive Health

Policy Year:
September 1 - August 31

Coverholder at LLOYD'S

Index

Best Doctors®
CANADA INSURANCE SERVICES INC

GLOBAL MEDICAL **CARE**™

SUMMARY OF BENEFITS

Global Medical Care Plan provides health care coverage that enables you to access care anywhere in the world. The maximum benefit amounts included in your policy once annual deductible has been met are indicated below.

Benefit	Coverage
Maximum Benefit	• $1 million per person, per policy year (September 1 - August 31) • $500,000 per person over the age of 70, per policy year
Deductible	• $5,000
Renewal	• Annual
Coverage	• Worldwide
Standard Room (semi-private)	• 100% with no limit on the number of days.
Intensive Care Unit/Life Support	• Maximum of $5,000 per day (room and board) up to a maximum of 90 days.
Outpatient Surgery	• 100%
Emergency Room	• 100%
Diagnostic Services	• 100%
Cancer Treatment	• 100%
Dialysis	• 100%
Maternity Benefit	• After the deductible, Best Doctors Canada Insurance Services will pay 50% of the next $100,000 of eligible medical expenses, then 100% to a maximum of $250,000. Covered maternity expenses include prenatal care, delivery, and postnatal care. • Maternity coverage has a 12-month waiting period from the date the policy was issued. • Dependent daughters are not eligible for maternity coverage.
Inclusion of Newborn	• Automatically covered as a dependent if born to a mother with maternity benefits.
Transplants	• $1,000,000 lifetime maximum and $20,000 for living donor.
Physical Therapy and Rehabilitation	• $5,000 per person per year.
Durable Medical Equipment	• Maximum of $5,000 per person.
Prescription/Life Sustaining Drugs	• Outpatient: $5,000 per person per year. • Inpatient: unlimited
Air Ambulance	• Maximum of $45,000 per person.
Ground Ambulance	• 100%
Repatriation of Mortal Remains	• Maximum $25,000 in the event of death during a covered hospitalization outside the country of residence.
Congenital Conditions	• $150,000 per lifetime if manifested before age 18. • $1,000,000 per lifetime if manifested after age 18.

Special Conditions	• Pre-existing conditions are not covered by policy for the first Thirty-Six (36) months of the policy. After Thirty-Six (36) months, the insured will be covered for any pre-existing conditions that are not specifically excluded from the policy. • Maximum $50,000 per Policy year for any or all pre-existing conditions as of the Thirty-Seventh (37th) month. • N/A

All benefits are in Canadian Dollars per person, per policy year, unless indicated otherwise. Covered medical expenses are subject to being usual, reasonable and customary.

The insurance policy is underwritten by certain underwriters at Lloyd's. Lloyd's is authorized under the Financial Services and Markets Act 2000 (UK). Lloyd's underwriters are authorized under the Insurance Companies Act (Canada). For the purpose of the Insurance Companies Act (Canada), the policy is issued in the course of Lloyd's Underwriters' Insurance business in Canada. Best Doctors Canada Insurance Services is a Lloyd's Coverholder. Complete definitions and limitations are found in the Master Policy.
BestDoctorsInsurance.ca

TELADOC Medical Experts | Best Doctors CANADA INSURANCE SERVICES INC

Unique Services

When facing the uncertainty of a tough medical condition, trying to find information can be just as stressful as dealing with the diagnosis itself.

With your Global Medical Care Corporate Plan, you have access to Teladoc Medical Experts Services, which can help you better understand your medical condition and treatment options:

Expert Medical Opinion
Review an existing diagnosis and treatment with a world-renowned expert to confirm or recommend a change of treatment.

Elite Diagnostic Imaging Service
Receive an MRI or CT scan within a matter of days of your doctor's appointment so you can move forward with treatment and care sooner. (Elite Diagnostic Imaging Service availability is based on the member's location in Canada).

Personal Health Navigator
Get a variety of information that's specific to your condition from registered healthcare professionals, including articles and community resources that can assist your medical needs.

Find a Doctor
Provides a list of local in-person experts that meet your specific medical needs.

Care Finder
Helps you locate specialists or facilities outside of Canada for your treatment/condition needs.

Teladoc Medical Experts is a value-added service included with the purchase of health insurance plans from Best Doctors Canada Insurance. Teladoc Medical Experts isn't included as part of the policy; therefore, its availability cannot be guaranteed. This service may be withdrawn or modified at any time without notice.

For more information on Teladoc Medical Experts, call 1.877.419.2378 or visit www.Teladoc.ca/medical-experts.

IT IS MANDATORY TO CONTACT THE BEST DOCTORS CANADA INSURANCE NOTIFICATION CENTRE AS FOLLOWS:

- **ELECTIVE ADMISSIONS/INPATIENT/OUTPATIENT:** Notify at least 7 days prior to the service date.
- **EMERGENCIES:** Notify within 48 hours.

NOTIFICATION CENTRE

Canada and the United States (Toll Free):
1.855.396.7188

International (Collect): 1.305.269.2521
Fax: 1.416.775.2480
Email: precert@bestdoctorsinsurance.com

CLAIMS SUBMISSION & REIMBURSEMENT

Send your claim form and receipts to:
claimscanada@bestdoctorsinsurance.com

ART. 01 ACCEPTANCE OF THE INSURANCE

The Health Insurance Policy is underwritten by certain underwriters at Lloyd's. Best Doctors Canada Insurance Services Inc. (the Insurance Company) has issued this policy to insure the risk of the Insured Entity. The Insurance Company agrees to pay for any covered medical treatment, service, or medical supply that the Insured Entity's members, their spouses, and dependents named under the policy (Covered Persons) receive. All benefits are subject to the terms and conditions of the policy.

Ten (10) day right to examine the policy
The Insured Entity reserves the right to cancel this policy within ten (10) days after receiving it for a refund of all premiums paid, minus any administrative fee paid per member. The cancellation of the policy can be informed directly to the Insurance Company or to the Insured Entity's agent. If canceled, the policy is considered null and void as though no policy had been issued. If not canceled within such ten (10) day period any refund requested will be processed, pursuant to article 9.11.

Important notice
The coverage for each Covered Person under this policy is issued based on the enrollment information submitted by the Insured Entity and the payment of the premium. If any information shown on the enrollment file is incorrect, incomplete, or if any information has been omitted, the policy may be rescinded, cancelled, or coverage may be modified, at the discretion of the Insurance Company.

The health insurance coverage does not provide payment of or reimbursement indemnification for all or any part of the cost of any services or supplies performed for a Covered Person in Canada that would be covered for that person by the provincial health insurance plan or any government-sponsored program in the Covered Person's home province. The plan will cover expenses for enhanced services or supplies that the Insurance Company believes are clinically appropriate in the circumstances. For avoidance of doubt, services that may be paid for privately in Canada are covered in this plan, pursuant to the terms and conditions of the policy. Benefits in Canada for members and/or their family are not payable under this policy if covered under a government plan or covered under an extended health care group plan.

ART. 02 COMMENCEMENT, DURATION, AND TERMINATION OF COVERAGE

The Insurance Company reserves the right to accept or deny any entity's application. Coverage begins at 00:01 hours Eastern Standard Time on the date stated in the policy contract following the date that the Insurance Company approves the application and receives payment of the premium. Coverage ends at 24:00 hours Eastern Standard Time on the policy termination date. The coverage has a duration period of twelve (12) months and shall be renewed automatically for a similar period of time with the corresponding premium payment subject to the definitions, conditions and other provisions of the policy.

ART. 03 ELIGIBILITY AND ENROLLMENT

3.1 Coverage for eligible members

The Insured Entity will receive coverage for members that meet the following requirements (eligible members):

a. Are a resident of Canada.

b. Are a direct member of the Insured Entity.

c. Are covered under the provincial health plan in the province of residence.

d. Are at least eighteen (18) years old (except for dependents or unless authorized by the parents or legal guardian). The maximum age required when applying for coverage is seventy-five (75) years of age. After seventy (70) years of age, the total coverage amount of the policy has a maximum benefit of five hundred thousand dollars ($500,000) per Insured, per policy year.

3.2 Coverage for eligible spouse and dependent children

a. An eligible spouse or partner must be legally married to or in a civil union with the policyholder, living with the policyholder in a conjugal relationship, and represented as such.

b. Eligible dependent children are those born to the policyholder, adopted by the policyholder, or a stepchild of the policyholder, who are also under the age of nineteen (19) or under the age of twenty-four (24) and attending an accredited college or university full-time.

   Coverage for dependent children will remain in effect until the following policy anniversary date after having reached eighteen (18) years of age, if single. Coverage for dependent children older than eighteen (18) years of age may remain effective if they are single and full-time students at an accredited school and until the following policy anniversary date upon their twenty-fourth (24th) birthday. The Insurance Company reserves the right to request a student certification from the university or college in which the student is enrolled.

c. If a dependent child marries, discontinues being a full-time student, or if the dependent spouse ceases to be married to the member by reason of divorce or annulment, coverage for such a dependent will terminate on the date such change occurs.

d. If the member did not request coverage for an eligible spouse or dependent child when enrolled, the Insured Entity must submit proof of their insurability in order to add them to the policy. Coverage will go into effect on the first day of the month following the date on which the Insurance Company recognizes the proof of insurability to be satisfactory, provided that any premium required has been paid in full.

e. For Newborns born under the policy, notification must be received within the first thirty (30) days of birth, and any additional premium required must be paid in full. If the Newborn is not properly enrolled within a period of thirty (30) days, acceptable proof of insurability must be submitted by the Insured Entity to the Insurance Company.

3.3 Enrollment

a. The eligible person must be a direct member of the insured Entity.

b. Covered Persons will be automatically insured at open enrollment after the inception of the policy.

c. If the person is no longer an active member of the Insured Entity, the Insured Entity's coverage for the member, spouse, and dependents will terminate on the same date of the event.

ART. 04 DEDUCTIBLE RESPONSIBILITY

The deductible indicated in the Certificate of Coverage is the portion of covered expenses that must be paid by each Covered Person before benefits are paid.

One (1) deductible per Covered Person, per policy year will apply. For family policies, a maximum of two (2) deductibles per policy, per policy year will be applied. All amounts applied to the deductible for each of the different members of the family on the same policy, will be taken into account to reach the two (2) deductibles.

ART. 05 POLICY PROVISIONS

5.1 Anesthesiologist fees

Coverage for anesthesiologist fees is limited to the lesser benefit of the following:

a. Thirty percent (30%) of the usual, reasonable and customary principal surgeon's fee for the surgical procedure in question, or

b. Thirty percent (30%) of the approved fees for the principal surgeon for the surgical procedure, or

c. One hundred percent (100%) of the usual, reasonable and customary anesthesiologist fees, or

d. Special rates established or contracted by the Insurance Company for an area, country or determined provider.

5.2 Assisting physician/surgeon fees

Coverage for assisting physician/surgeon fees is limited to the lesser benefit of the following:

a. Twenty percent (20%) of the approved fees for the principal surgeon for the procedure, or

b. If more than one assisting physician/surgeon is required, the maximum coverage for all assisting physicians/surgeons shall not exceed twenty percent (20%) of the principal surgeon's fee for the actual surgical procedure, or

c. One hundred percent (100%) of the usual, reasonable and customary assisting physician/surgeon's fees for the surgical procedure in question, or

d. Special rates established or contracted by the Insurance Company for an area, country or determined provider.

5.3 Benefits after 70 years of age

After seventy (70) years of age, the total coverage amount of the policy has a maximum benefit of five hundred thousand dollars ($500,000) per insured, per policy year.

5.4 Coverage for reconstructive and/or cosmetic surgery

Benefits will be paid only if is performed during the first six (6) months after the procedure took place and when the surgery is:

a. Medically necessary and essential for the treatment of an illness or injury that occurs while the person is covered and such condition is a benefit under this policy;

b. Required in relation to an injury caused by an accident or a deformity that occurs for the first time while the Insured Entity had such a person on its eligibility coverage file;

c. Required for the treatment of nasal deformities or of the nasal septum caused by trauma due to an accident. This surgery must be previously approved by the Insurance Company. Evidence of trauma resulting in a fracture must be confirmed by radiological testing (X-rays, scans, magnetic imaging, etc.).

5.5 Covered expenses

As stated in this policy and subject to the stipulations within the conditions of coverage and all remaining dispositions and conditions, covered expenses shall be defined as the usual, reasonable and customary charges incurred by the Covered Person during the period that this policy is in force. These expenses include treatments, medical services or supplies that are incurred as a result of, or in relation to, the treatment of illnesses or covered medical conditions that are deemed medically necessary. Covered expenses are incurred charges for:

a. Medical, Surgical and Hospital Services
b. Diagnostic Services as defined in this policy
c. Prescribed Medications, Medical Equipment, and Surgical Implants. The Insured Entity will receive coverage for these benefits as described in this section, subject to the limitations and exclusions as described in other sections of the conditions of coverage.

5.6 Durable medical equipment or special devices

External prosthesis, orthotic devices, durable medical equipment (for rent or sale) and implants will be covered up to a maximum of five thousand dollars ($5,000) per person, after the corresponding deductible has been met. This benefit must be coordinated and approved in advance by the Insurance Company. In the event that it is approved and acquired, reimbursement will be made in accordance with the usual, reasonable and customary cost within the geographical area.

5.7 Emergency transportation

Emergency transportation (by ground and air ambulance) is only covered if related to a covered condition for which treatment cannot be provided locally and transportation by any other method would result in loss of life or limb. Emergency transportation must be provided to the nearest medical facility by a licensed and authorized transportation company. The vehicle or aircraft used must be staffed by medically trained personnel and must be equipped to handle medical emergencies. Air ambulance transportation:

a. All air ambulance transportation must be pre-approved and coordinated by the Insurance Company;
b. The amount payable for this benefit is the actual amount up to a maximum of forty-five thousand dollars ($45,000) per person, per policy year;
c. The Insured Entity (and all members and dependents who request and are approved for use of an Air Ambulance) agree to hold the Insurance Company and any company affiliated with the Insurance Company, harmless from any negligence resulting from such services, or for delays or restrictions on flights caused by mechanical problems, by governmental restrictions, by the airline, or by the pilot, or due to operational conditions or bad weather. Ground ambulance transportation: The maximum amount payable for this benefit is unlimited.

5.8 Illness or injury in a private aircraft

Any illness or injury sustained as a passenger, pilot and/or member of the crew in a private aircraft is covered in accordance with the terms of this policy.

5.9 Outpatient physical therapy and home health care

Coverage for this care or treatment must be approved in advance by the Insurance Company, including any and all extensions. In all cases, the Insurance Company must receive the treatment plan and evidence of medical need. The maximum amount paid for this benefit is five thousand dollars ($5,000) per person, after the corresponding deductible has been met.

5.10 Prescription /Life sustaining drugs

The maximum benefit on an Outpatient basis is five thousand dollars ($5,000) per person, per policy year after the corresponding deductible has been met. As an Inpatient, the maximum is unlimited. Approved drugs are covered on a usual, reasonable and customary basis. The covered expenses are limited to medications that:

a. Require a medical prescription for use, (or in the case of life sustaining drugs are medically necessary as determined by the treating physician) and are not sold over-the-counter;

b. Are provided by an authorized pharmacist;

c. Are approved by the Food and Drug Administration (FDA) of the United States of America or the Health Products and Food Branch (HPFB) of Health Canada, and according to the specified regulations that apply to the country in which treatment is being received. In all cases, a copy of the prescription must accompany the claim.

5.11 Repatriation of mortal remains

In the event a Covered Person dies outside of his/her country of residence, the Insurance Company will pay up to five thousand dollars ($5,000) for the repatriation of the deceased's remains to the country of residence. This benefit will always be offered provided that the death resulted from a hospitalization which would have been covered. Coverage is limited to only those services and supplies necessary to prepare the deceased's body and to transport the deceased to his/her country of residence. This benefit will apply after exhausting any similar benefit, independent of this policy.

5.12 Surgeon fees

Coverage for surgeon fees are limited to the lesser benefit of the following:

a. One hundred percent (100%) of the usual, reasonable and customary fees for the actual surgical procedure; or

b. One hundred percent (100%) of the approved surgeon's fee for the procedure; or

c. Special rates established or contracted by the Insurance Company for an area, country or determined provider.

d. In the event a surgical procedure is performed and another one is incidentally necessary, the principal, most important procedure will be paid in accordance with the lesser benefit of points a, b, c, described in this section. The secondary procedure will be paid at fifty per cent (50%) in relation to the principal procedure, and the third and subsequent ones will be paid at twenty-five percent (25%) in relation to the principal procedure.

5.13 Transplant coverage

It is a requirement for this benefit that the person seeking this service obtains approval from the Insurance Company prior to receiving service. This benefit must be coordinated by the Insurance Company. Notification by the Insured Entity or the Covered Person is required.

No payments will be made for any treatment, procedure, service, or surgery when:

a. It is not medically necessary;

b. It is considered elective, experimental or investigative;

c. It is performed when the person had access to alternative procedures and/or treatments, with the same level of results and care, to treat the medical condition or illness that caused the need for a transplant;

d. It is originated by or as a result of a transplant from the use of a mechanic artifact or artificial equipment the aim of which is to replace a human organ or where the donor is an animal;

e. It is performed because of an initial failed transplant carried out prior to the start cover date of this policy.

5.14 Maternity care

a. After the deductible, the Insurance Company will pay fifty percent (50%) of the next one hundred thousand dollars ($100,000) of the medical eligible expenses, then one hundred percent (100%) to a maximum of two hundred and fifty thousand dollars ($250,000);

b. Pre and post-natal treatment, childbirth, complications of pregnancy or delivery, and well-baby care are included in the maximum maternity benefit listed in this policy;

c. Maternity coverage has a twelve (12) month waiting period, whether or not the thirty (30) day grace period for coverage of this policy has been waived;

d. There is no maternity coverage for dependent daughters. Those Covered Persons who were previously dependent daughters under another policy with the Insurance Company, must have maintained their own individual policy for a minimum of twelve (12) months to be eligible for this maternity care benefit.

5.15 Newborn coverage

If born within a covered maternity: Policy limits for complications of birth relating to a newborn are limited to the maximum benefits as specified in the conditions described within the provision for "Maternity Care" (article 5.14). The inclusion for the newborn must be received within the first thirty (30) days of birth. If such notification is not received within the first thirty (30) days of birth, then an application requesting additional dependent coverage is required for the newborn and will be subject to medical underwriting. The payment of the corresponding premium must be received within thirty (30) days from the date on which the inclusion for the newborn was made.

Routine medical care for a healthy newborn will be covered as specified in the conditions described within the provision for "Maternity Care" (article 5.14) of this policy.

If born within a non-covered maternity or born of a pregnancy that is a result of any type of fertility treatment: Children born from a non-covered maternity or born of a pregnancy that is a result of any type of fertility treatment will not have automatic coverage as a newborn.

In order to add a newborn to the policy, if applying after 30 days of birth, the Insured must submit a complete application for insurance which is subject to medical underwriting by the Insurance Company.

ART. 06 EXCLUSIONS AND LIMITATIONS

Coverage or benefits will not be provided to the Insured Entity for any of the following treatments delivered to its Covered Persons:

6.1 Any treatment, injury, illness or charges arising from any service or supply which is:

a. Not medically necessary, or

b. For a person who is not under the care of a physician, doctor or legally skilled professional, or

c. Not authorized or prescribed by a physician or doctor or legally skilled professional, or

d. Custodial or hospice care, or

e. Related to personal care.

6.2 Any care or treatment for self-inflicted injuries or illness, while the person is sane or insane, suicide, failed suicide, alcohol abuse, drug use or abuse, or the use of illegal substances or illegal use of controlled substances. This includes any accidents resulting from any of these criteria.

6.3 Routine eye and ear examinations, hearing aids, eye glasses, contact lenses, radial keratotomy and/or other procedures to correct eye refraction disorders.

6.4 Any medical examination or diagnostic study which is part of a routine physical examination, prophylactic treatments, including vaccinations and the issuance of medical certificates and examinations as to the suitability of the member or dependent for employment or travel.

6.5 Any chiropractic care, homeopathic treatment, acupuncture or any type of alternative medicine.

6.6 Elective or cosmetic surgery or medical treatment whose main purpose is for beautification, unless necessitated by injury, deformity or illness which first occurs while the Insured Entity has coverage for such person's injury under this policy. Also excluded is any surgical treatment for nasal or nasal septum deformity that was not induced by trauma, except as provided for in this policy.

6.7 Any expense related to pre-existing conditions as defined within this policy in the first thirty-six (36) months.

6.8 Any treatment, service or supply that is not scientifically or medically recognized for the prescribed treatment, or which is considered experimental and/or not approved for general use by the Food and Drug Administration (FDA) of the United States or The Health Products and Food Branch Health Canada.

6.9 Any payment of or reimbursement or indemnification for all or any part of the cost of any services or supplies performed for or provided to a Covered Person that would be covered for that person under any government-sponsored health insurance plan and/or workplace injury insurance plan in effect in the province in which the Covered Person is resident, or supplemental health services covered under an applicable plan of automobile insurance; provided, however, that the coverage will include expenses for enhanced services or supplies that are not otherwise provided for a Covered Person, or which exceed the amount of the Insured's benefits payable, by a government-sponsored program then in effect in the province in which the Covered Person is resident or an applicable plan of automobile insurance, and that Covered Person deems to be clinically appropriate in the circumstances.

6.10 Diagnostic procedures or treatment of mental or psychiatric illnesses, behavioural or developmental disorders, Chronic Fatigue Syndrome, sleep apnea and any other sleep disorder.

6.11 Any portion of any charge that is in excess of the usual, reasonable and customary charge for the particular service or supply for that geographical area.

6.12 Any expense for male or female sterilization, reversal of sterilization, sex change, sexual transformation, birth control, infertility treatment, artificial insemination or prosthesis to improve or restore sexual dysfunction or inadequacies, disorders related to Human Papilloma Virus (HPV) and/or sexually transmitted diseases.

6.13 Any expense, service or treatment for obesity, weight control or any form of food supplement, including bariatric surgery and gastric "by-pass" surgery, its complications and treatments. Also excluded is any type of surgical procedure for weight loss.

6.14 Podiatric care to treat functional disorders of the structures of the feet, including but

not limited to: corns, calluses, bunions, hallux valgus, hammer toe, Morton's Neuroma, flat feet, weak arches, weak feet or other symptomatic complaints of the feet, including pedicures, special shoes and inserts of any type or form.

6.15 Any treatment relating to growth hormone, regardless of the reason for prescription, and treatment by bone growth stimulator, or bone growth stimulation.

6.16 All treatment to a mother or a newborn related to a non-covered pregnancy.

6.17 Any voluntary induced termination of pregnancy, unless a doctor determines an imminent danger to the mother's life.

6.18 Any congenital or hereditary disorder or illness, except as provided for under the provisions of this policy.

6.19 Any dental treatment or orthodontics related or not to a mandible problem, not related to a covered accident or not reported within ninety (90) days of the date of such accident. Treatment of the upper maxilla, the jaw or jaw joint disorders, including but not limited to jaw anomalies, malformations, Temporo mandibular Joint Syndrome, craniomandibular disorders or other conditions of the jaw or the jaw joint linking the jawbone and the skull and all muscles, nerves and other tissues linked to this joint.

6.20 Treatment of injuries resulting while the Insured is in service as a member of a police or military unit or from participation in war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, act of terrorism. For the purpose of the exclusion under this Insurance 'an act of terrorism' means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious or ideological purposes or reasons including the intention to influence any government and/or put the public, or any section of the public, in fear.

6.21 Any expense directly or indirectly arising out of contamination due to an act of terrorism, regardless of any contributory causes, including but not limited to weapons of mass destruction, including chemical, biological or nuclear contamination.

6.22 Any hospital admission more than twenty-four (24) hours before a planned surgery or any additional hospitalization for a mother remaining in the medical facility due to a newborn hospitalization, except if approved by the Insurance Company.

6.23 Any treatment rendered by a family member, including but not limited to the spouse, father, mother, children or by another person who regularly resides in the insured's home, or any treatment provided in any entity or facility owned by, or under the operation, of a family member.

6.24 Any over-the-counter medicine or non-prescription drug unless approved in advance by the Insurance Company.

6.25 Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or illnesses as a consequence of AIDS and HIV.

6.26 Any dietary supplement, appetite suppressant, vitamins, anti-aging medicine, medications or treatment for hair regeneration.

6.27 Personal artificial kidney equipment for home use and all related expenses.

6.28 Any cost relating to the acquisition and implantation of an artificial heart, mono or bi-ventricular devices, other artificial or animal organs and all expenses related with cryopreservation lasting more than twenty-four (24) hours.

6.29 Injuries or illness caused by, or related to ionized radiation, pollution or contamination, radioactivity from any nuclear material, nuclear waste, or the combustion of nuclear fuel or nuclear devices.

6.30 Any expense related to extraction, repair or replacement of damaged medical equipment (unless the product lifecycle has expired).

6.31 Any expense related to the duplication of functions of medical equipment that produce the same result.

6.32 Treatment rendered by more than one surgical assistant, unless approved by the Insurance Company.

6.33 Any expense related to recreational or educational therapy.

6.34 Any expense related to custodial charges in case of senility or loss of mental faculties.

6.35 Any custodial assistance, home health aides including but not limited to maintenance care or therapy for chronic conditions. Treatment, services, and supplies provided by facilities that are mental institutions, nursing homes, assisted living facilities, long term care facilities, health spas, and water therapy spas.

6.36 Any injury, accident or illness caused as a result of direct professional practice or participation in competitive sports or dangerous activities.

6.37 Any part of the cost of any services or supplies performed for a Covered Person in Canada that would be covered for that person by the provincial health insurance plan or any government-sponsored program in the insured's home province. The plan will cover expenses for enhanced services or supplies that the Insurance Company believes are clinically appropriate in the circumstances. For avoidance of doubt, services that may be paid for privately in Canada are covered under this plan pursuant to the terms and conditions of the policy.

6.38 Benefits in Canada for members and/or their family are not payable under this policy if covered under a government plan or covered under an extended health care group plan.

ART. 07 HOW AND WHEN TO NOTIFY AND GET PRE-AUTHORIZATION

Benefits related to the treatment of an illness or medical condition covered by this policy are subject to advance notice (Notification). Any major medical procedure requires a Pre-Authorization allowing the Insurance Company to confirm the Covered Person's eligibility and coverage amount. The person must notify the Insurance Company, by calling the telephone number that appears on the reverse of the identification card, at least seventy-two (72) hours prior to receiving any medical treatment that is not an emergency. All medical emergencies must be notified within forty-eight (48) hours after the event. Failure to comply with the above will result in a penalty of thirty percent (30%) of all covered costs, including, but not limited to medical costs, hospitalization, and diagnostic testing, in addition to the deductible (if applicable).

ART. 08 HOW TO REPORT A CLAIM

The Covered Person must present a bill for reimbursement to the Insurance Company for all expenses of the covered costs within the conditions stated in this policy, not including those cases for which the provider has agreed to receive payment directly from the Insurance Company. In order to comply fully with this claim procedure, the Covered Person must:

8.1 Present a properly completed and signed claim form accompanied by a medical report.

8.2 Submit original bills and/or receipts itemized by hospital charge, pharmacy, treating physicians, diagnostic tests, lab exams, etc. Photocopies shall not be regarded as acceptable documentation.

8.3 Each receipt shall present the following information:

a. Covered Person's name and date of birth;

b. Diagnosis and type of service received (consultations, procedure, diagnostic or other tests, hospitalization, etc);

c. Date, itemized amount of the service received and proof of payment;

d. In the case of a pharmacy expense, both the itemized paid pharmacy invoice and the medical prescription must be submitted, as well as a clear indication of the medicines on the invoice or items that do not pertain to the doctor's prescription or condition treated;

e. In the event that two (2) claims are filed for reimbursement simultaneously from different persons, separate itemized expenses per person, by illness and provider must be detailed and submitted.

If the information that is provided is inadequate or incomplete, it may delay the reimbursement process or temporarily close the claim until the required information is received. Claims must be received within the first one hundred eighty (180) days following the treatment service date. If the information is not received within the established period of time, the claim will be denied.

ART. 09 ADMINISTRATION

The Covered Person must present a bill for reimbursement to the Insurance Company for all expenses of the covered costs within the conditions stated in this policy, not including those cases for which the provider has agreed to receive payment directly from the Insurance Company.

9.1 Several liability notice

The subscribing insurers' obligations under contracts of insurance to which they subscribe are several and not joint and are limited solely to the extent of their individual subscriptions. The subscribing insurers are not responsible for the subscription of any co-subscribing insurer who for any reason does not satisfy all or part of its obligations.

9.2 Service of suit clause (Action against Insurance Company)

In any action to enforce the obligations of the Underwriters they can be designated or named as "Lloyd's Underwriters" and such designation shall be binding on the Underwriters as if they had each been individually named as defendant. Service of such proceedings may validly be made upon the Attorney In Fact in Canada for Lloyd's Underwriters, whose address for such service is 1155, rue Metcalfe, Suite 2220, Montreal, Quebec, H3B 2V6.

9.3 Delivery of medical information to agent of record

The Insured Entity and its members and dependents specifically understand and agree that they have elected to allow the Agent of Record (Agent) to have access to all of the health and medical information (past, present and future) that is ever delivered to the Insurance Company or any one of its affiliates or subcontractors. The Insured Entity and its Covered Persons have requested the Insurance Company to make this information available to the Agent in order to facilitate the transfer of information between the Insured Entity, Covered Persons and the Insurance Company in the processing of claims. The Insured Entity has requested this access to the Agent from the Insurance Company, and it is not an obligation that the Insurance Company requires the Covered Person or Insured Entity to consent. Instead the Insured Entity has knowingly and voluntarily requested such provision of access and information to the Agent. The Insured Entity hereby agrees that the Insurance Company may provide and/or deliver this information to the Agent in any manner that the Insurance Company so elects, in its sole discretion.

9.4 Authority

No Agent has the authority to change the policy or to waive any of its provisions. After issuance, no change in the policy shall be valid unless approved in writing by an officer approved by the Insurance Company and such approval is endorsed by an amendment to the policy.

9.5 Change of country of residence

The Insured Entity must notify the Insurance Company in writing of any changes to any Covered Person's country of residence to another country within the first thirty (30) days of its occurrence. Changes of residence could result in a cancellation, modification or an adjustment of premium for the Covered Person who is changing his/her residence. Failure to notify the Insurance Company may result in cancellation of a Covered Person eligibility.

9.6 Commencement of insurance

Benefits begin on the cover start date of the policy, subject to the provisions of this policy.

9.7 Other insurance coverage

Should there be other health insurance, including government-sponsored programs, it must be declared at the time it is acquired or upon completing the original application. Upon filing a claim document, proof of coverage and a copy of the claim details, along with proof of payment of expenses by the other health insurance (EOB) must be submitted. The Insurance Company will begin the process of coordination of benefits by which the amounts paid by the other insurance will be applied to the deductible, according to the benefits and limitations of this policy. The Insurance Company shall not pay any claim if there is other insurance which would, or would but for the existence of this insurance pay such a claim. This insurance will apply for expenses in excess of the amount paid or payable under such other insurance. The Insurance Company shall not pay any claim in respect to care, treatment, services or supplies furnished by any program or agency funded by any government.

9.8 Entire contract

The application, certificate of coverage and the conditions of coverage and any riders or amendments shall constitute the entire contract between the parties.

9.9 Payment of claims
The Insurance Company will make payments directly to physicians and hospitals world-wide. When this is not possible, the Insurance Company will reimburse the Covered Person in accordance with the usual, reasonable and customary fees for that geographical area.

9.10 Proof of claim
Reimbursement requests or claims related to medical services must be submitted to the Insurance Company. This information must be received within the first one hundred and eighty (180) days after the treatment or service date. Failure to do so will result in denial of the claim. Claims must be original itemized bills detailing each service included. It must also be accompanied by the properly completed and signed claim form. The medical files or records are also required.

9.11 Refunds
If the Insurance Company cancels the policy after it has been issued, reinstated or renewed, the Insurance Company will refund the unearned portion of the premium, less administrative charges and policy issuance fees. The unearned portion of the premium is based on the number of days corresponding to the payment mode, minus the number of days the policy was in force.

The insured Entity must give thirty (30) days written notice prior to the anniversary date to effect the cancellation of coverage.

9.12 Currency
All currency values stated in this policy are in Canadian Dollars (CAD). The exchange rate used to pay claims generated in a currency other than Canadian Dollars (CAD), will be calculated at the daily 12-noon buying rates as published by the Bank of Canada, Ottawa, Canada for that date of service.

9.13 Physical examinations
The Insurance Company, at its own expense, reserves the right to request a medical examination or second opinion to any person whose illness or injury is the basis of a claim, when and as often as considered necessary by the Insurance Company while the claim is in process.

9.14 Medical reports
The Insurance Company will request all medical files and/or reports necessary directly from the provider in those cases that a direct payment was made, or to the Insured Member in the case of reimbursement. The Covered Person will be the ultimate responsible party for obtaining these medical records and reports. In order to obtain such records, the Insurance Company needs the signed authorization of the person for whom services are to be rendered on all forms that the provider of medical services requires. Failure to obtain such authorization and the necessary medical records and reports, could result in the delay or denial of a claim.

9.15 Policy cancellation or non-renewal
The Insurance Company retains the right to cancel the policy if the premium due is not paid, by which the Insured Entity will only have coverage for the period covered by the premium paid, or if statements on the application of the group or any of the members are found to be misrepresentations, incomplete or if fraud has been committed.

9.16 Fraud
If any of the insured under the Insured Entity attempts or succeeds, by misrepresentation or deceit, in obtaining coverage benefits for itself or a person to which it would not have been entitled or would not have been payable otherwise, this policy may be terminated automatically by the Insurance Company for that particular insured.

9.17 Policy mode
All policies are considered annual policies. Premiums can be paid annually, semi-annually, quarterly, or monthly.

9.18 Grace period
A thirty (30) day grace period is allowed for the payment of the premium. If the premium is not paid within the grace period, the Insurance Company will terminate coverage at 11:59 PM on the last day of the period for which the premium was last paid. Benefits are not provided under the policy after the expiration of the grace period unless the policy is reinstated.

9.19 Premium payment
On-time payment of the premium is the responsibility of the Insured Entity. The premium is payable on the renewal date of the policy or other due dates if authorized by the Insurance Company. Premium notices are provided as a courtesy to the Insured Entity, and the Insurance Company provides no guarantee of delivering such notices. If the Insured Entity does not receive a premium notice thirty (30) days prior to the due date and the Insured Entity does not know the amount of the premium payment, the Insured Entity should contact its Agent or the Insurance Company representative.

9.20 Rate changes
The Insurance Company reserves the right to adjust rates for the group upon renewal of the policy. The rate adjustment will be based on various factors including: experience of the group, changes to risk profile of the group, changes to cost of medical services as well as any other factors that would significantly impact the utilization patterns of the group.

9.21 Reinstatement of the policy
All policies reinstated after the thirty (30) day grace period are deemed new policies with no antiquity or credit being afforded to the Insured Entity. All medical conditions existing prior to the date of reinstatement of the policy shall be considered and treated as pre-existing conditions under this policy. No reinstatement will be authorized ninety (90) days after the date of termination of the policy.

9.22 Prior approval for some external medical services or home health care
Prior to receiving home health assistance or terminally ill assistance, these services must be approved by the Insurance Company in order to be covered under this contract.

9.23 Individual case management
A program for managing benefits of a person in certain situations. Through this program, the Insurance Company works with providers to ensure that a person receives medically necessary services within the least intensive context that is adapted to the person's needs. Individual Case Management is a service offered to members whose medical condition would otherwise require hospitalization.

9.24 Claims appeals
In the event of any disagreement between the Insured Entity and the Insurance Company regarding the policy and/or its provisions, the Insured Entity can request a review of the case by the Insurance Company. In order to begin such a review, the Insured Entity must submit a written request that must include copies of all relevant information. Upon the submission of a request for review, the Insurance Company will determine whether any additional information and/or documentation is needed, and act in a timely manner to obtain such information. The Insurance Company will notify the Insured Entity of its decision and the underlying rationale on which it is based within thirty (30) days thereafter.

9.25 Negotiation and Jurisdiction

In the event of any dispute, claim, or controversy arising under or in connection with this Policy ("Dispute") the Insurance Company and the Insured Entity or the Covered Person (individually "Party" and collectively "Parties") shall first attempt to settle the Dispute in good faith through amicable negotiation ("Negotiation"). The Negotiation will be commenced by either Party providing written notice to the other Party requesting such Negotiation in Miami, Florida or through an agreed virtual conference platform ("the Negotiation Request").

No later than sixty (60) days after the date of the Negotiation Request, Parties shall attend for at least one (1) Negotiation session in Miami, Florida or through an agreed virtual conference platform. Any settlement agreement reached and fully executed by all Parties will be binding on all Parties. The Negotiation shall be treated as a settlement discussion and shall therefore be confidential and may not be used against either Party in any later proceeding relating to the Dispute. If the Negotiation does not resolve the dispute within sixty (60) days of the first Negotiation session, the Parties irrevocably consent to the venue and personal jurisdiction of the federal courts located in Miami-Dade County, Florida, in the United States of America.

9.26 Subrogation and indemnity

The Insurance Company has a right of subrogation or reimbursement from the Covered Person or Insured Entity if the Covered Person or Insured Entity has recovered all or part of such payments from a third party. Furthermore, the Insurance Company has the right to proceed at its own expense in the name of the Covered Person or Insured Entity against third parties who may be responsible for causing a claim under this policy or who may be responsible for providing indemnity of the claim against the other person(s) as well as if the payment that the Covered Person or Insured Entity receives is described as payment for other than health care expenses.

The amount the Covered Person or Insured Entity must reimburse the Insurance Company will not be reduced by any legal fees or expenses the Covered Person or Insured Entity incurs. The Covered Person or Insured Entity must cooperate with the Insurance Company, providing the necessary information, completing and signing all required documents to help the Insurance Company obtain reimbursement. This also means that the Covered Person or Insurance Entity must give the Insurance Company notice before settling any claim sustained by an act or omission of another person for which the Insurance Company paid benefits. The Covered Person or Insured Entity must not do anything that might limit the Insurance Company's right to full reimbursement.

9.27 Notification

The Insurance Company must be contacted for any medical service inquiry following the stipulations defined within this policy.

9.28 Termination of coverage after the policy termination date

There is no coverage for any treatment that occurs after the effective date of termination of this policy, regardless of when the condition first occurred or how much additional treatment may be required.

9.29 Change of plan or deductible

Upon the anniversary date, the Insured Entity can request to change to a plan with different deductibles. The Insurance Company reserves the right to accept any change of deductible in the annual renewal (if the change is for a lower deductible than the current one). Such requests may be subject to underwriting evaluation, and require approval. During the first ninety (90) days from the effective date of the change, benefits payable for any illness or injury not caused by accident or disease of infectious origin will be limited to the lesser of benefits provided by the new plan or the prior plan.

ART. 10 DEFINITIONS

Accident
Any sudden, unforeseen, or unintentional event produced exclusively by an external cause resulting directly from and independently of other causes in bodily injury.

Air ambulance
Emergency air transportation and medical personnel trained in the transfer of person from the hospital where the person is admitted to the nearest suitable hospital where adequate treatment can be provided.

Amendment
A document added to the policy by the Insurance Company that clarifies, explains or modifies the policy.

Anesthesiologist fees
Incurred charges by an anesthesiologist for the administration of anesthesia during a surgical procedure or services that are medically necessary for pain control.

Anniversary date
Date and time that is twelve (12) months after the effective date of the policy or from the last anniversary.

Applicant
The corporate group who signed the application for coverage.

Application
A written request by a proposed Insured Entity with information of the group members and/or their dependents used by the Insurance Company to determine coverage. The application includes any medical history, questionnaire, and other documents provided to or requested by the Insurance Company prior to the issuance of the policy.

Assisting physician/surgeon fees
Incurred charges by a physician or physicians who assist the principal surgeon during a surgical procedure.

Best Doctors Network
A group of diagnostic hospitals, clinics and centers approved by the Insurance Company.

Certificate of Coverage
Document of the policy that specifies the commencement, conditions, extent and any limitations of the coverage, and lists all Covered Persons.

Congenital and hereditary disorders or illnesses
Any disorder or illness existing before birth, regardless of its cause, whether or not manifested or diagnosed at birth, after birth, or years later.

Complications of birth
Any disorder related to the birth of a newborn (not caused by genetic factors), manifested during the first thirty (30) days of life, including, but not limited to, hyperbilirubinemia (jaundice), cerebral hypoxia, hypoglycemia, premature birth, respiratory distress, and birth trauma.

Country of residence
The country in which the Covered Person resides the majority of any calendar or policy year. This policy covers Covered Person residing in a Canadian province or territory.

Covered expenses
Covered expenses are defined in the "Policy Provisions" section of this policy.

Covered pregnancy
A covered pregnancy is one whose actual date of delivery is at least twelve (12) months after the first effective date of coverage (provided continuous coverage during such period) for the respective Covered mother.

Cover start date
The date on which coverage under this policy begins as is stated in the Certificate of Coverage. This date will only be effective after delivery of the insurance policy to the Insured Entity and the

expiration of the Ten (10) Day Right to Examine the Policy, during which the Insured Entity reserves the right to examine and return the policy.

Custodial care
Services rendered that include but are not limited to personal assistance that does not require the skills of a professional.

Diagnostic Services
Procedures performed to confirm, or determine the presence of disease in an individual suspected of having the disease, usually following the report of symptoms, or based on the results of other medical tests.

Due date
The date on which the premium is due and payable for the corresponding period. On the due date, all previous benefits and coverage end according to the conditions outlined in this document.

Durable medical equipment
Any medical equipment designed for continuous use. This includes, but is not limited to, wheelchairs, hospital beds, respirators, and crutches.

Emergency
A sudden and unforeseen medical condition or event manifested by acute signs or symptoms which could result in immediate danger to a person's life or physical integrity.

Emergency dental treatment
Treatment necessary to restore or replace sound natural teeth, damaged or lost in a covered accident. Benefits will be paid only if treatment is performed during the first six (6) months after the accident.

Emergency treatment
Medically necessary treatment due to an emergency.

Experimental or investigative
Any treatment, procedure, equipment, drugs, device or supply that does not comply with one or more of the following criteria:

a. Controlled clinical research published in medical literature reviewed by other professionals of the same category who show that this service or device has a clear, beneficial result for one's health for a specific diagnosis.

b. Such service or device complies with the norms generally accepted within the medical scope of practice in the United States of America or Canada.

c. At the time that the service or device is provided to the Covered Person, it has been approved for the specific indication or application in question by the United States Food and Drug Administration (FDA) and The Health Products and Food Branch (HPFB) of Health Canada, or other federal agency of the government, whose approval is required regardless of the location where the medical charges are incurred.

Grace period
The period of time of thirty (30) days after the policy due date during which the policy may be renewed.

Ground ambulance
Ground transportation with equipment and medical personnel trained in the transfer of the Covered Person.

Home health care
Health care which is prescribed and recommended in writing by a treating physician, as necessary for the proper treatment of the illness or injury at home in place of hospitalization. Home health care includes the services of skilled licensed professionals (nurses, therapists, etc.) outside of the hospital and does not include custodial care. This benefit has a maximum limit of one hundred and eighty (180) days within the policy year.

Hospital
Any facility which is legally licensed as a medical or surgical facility in the country in which it is located and is:

a. Primarily dedicated to providing clinical and surgical diagnoses for injured and ill persons under the supervision of a medical team

b. Not a place of rest, nursing or convalescent home or institution, or a facility for long term care.

Hospital services
Medical treatment or services ordered by a medical professional for a person who is admitted to a hospital.

Illness
A condition of the human body manifested by signs, symptoms and/or findings through medical exams and evaluations, which makes this condition different than the normal state of the body.

Injury
Damage inflicted to the body.

Insured Entity
This term refers to the corporation contracted under this policy.

Laboratory and x-ray services
X-ray services and laboratory testing to diagnose or treat medical conditions.

Living donor
A person capable of donating a bodily organ and able to live without such organ, which is compatible to the recipient of the organ.

Medically necessary or medical necessity
A medical service, supply, equipment, medication or hospital admission that:

a. Is appropriate and essential for the diagnosis and treatment of a person's illness;

b. Does not exceed the reach, duration or intensity of the level of care necessary to provide a safe, adequate and appropriate diagnosis and/or treatment;

c. Has been prescribed by a physician;

d. Is consistent with the professional norms accepted within the medical scope of practice in the United States of America or Canada, or by the medical community of the country where the medical service or treatment is rendered.

Newborn
An infant from the moment of birth through the first (1st) month of life.

Nurse
An individual legally licensed to provide nursing care to patients.

Outpatient services
Treatment or services provided that do not require a hospital admission. The services can be rendered in a hospital or emergency room.

Personalized services
The Insurance Company offers the coordination of medical appointments, hospital admission, travel arrangements and accommodations when services are rendered outside of the person's country of residence. The Covered Person is responsible for all travel and accommodation costs; the Insurance Company is not responsible for these costs.

Physician or doctor
A person who is legally licensed to practice medicine in the country where treatment is provided. The term "Physician" or "Doctor" shall also include persons legally licensed to practice Dentistry.

Policy year
The period of twelve (12) consecutive months beginning on the start cover date of the policy and the same period in the consecutive years.

Pre-existing condition
a. A condition which was diagnosed by a physician prior to the cover start date of the policy or its reinstatement; or

b. A condition for which a doctor was consulted and medical treatment was recommended or received prior to the cover start date of the policy or its reinstatement; or

c. A condition for which any symptom or sign, if presented to a physician prior to the start cover date of the policy, would have resulted in the diagnosis of an illness or medical condition.

Health conditions fitting the above definitions that occurred thirty-six (36) months prior to the policy start date are considered pre-existing conditions and are excluded from coverage for the first thirty-six (36) months of the policy. For example, a person with Multiple Sclerosis would not have coverage for the first thirty-six (36) months of an issued policy, but the Covered Person could access the coverage commencing in the thirty-seventh (37th) month.

The maximum benefit for any or all pre-existing conditions will be fifty thousand dollars ($50,000) per policy year, per Covered Person.

Prescription medications / Life sustaining drugs
Medications for which the sale and use are legally restricted to the order of a physician.

Primary procedure
The procedure that has been identified as such and for which the majority of the benefits attributable to a single person are paid under this policy.

Private aircraft
Any aircraft in a flight that is not regularly scheduled or chartered by a commercial airline.

Provider
The hospitals, diagnostic centres, physicians, pharmacies and any facility that provides legally authorized medical services.

Renewal date
The first day of the next policy year.

Rider
An optional benefit added to the policy by the Insurance Company at the Insured Entity's request to provide additional coverage.

Secondary procedure
In the event multiple procedures are performed, this procedure shall be the less complex and/or extensive and for which the lesser amount of benefits attributable to a single person shall be paid under this policy.

Semi-private room
A standard hospital room equipped to accommodate more than one patient.

Spouse
The individual that is legally married to or in a civil union with the policyholder or living with the policyholder in a conjugal relationship for at least twelve (12) continuous months and represented as the spouse or partner.

Transplant
Medically necessary procedure by which organs, skin or cells are surgically transplanted from a living or deceased donor to the recipient.

Usual, Reasonable and Customary
Charges or fees for any medical service provided in a determined geographical area, regardless of whether or not the payment was made directly or issued as a refund. The Usual, Reasonable, and Customary fees are defined by the Insurance Company's medical team.

Well-baby care
Routine medical care provided to a healthy newborn.

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Be certain you're making the right medical decision.

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