GlobalMedical*Care*™

Terms & Conditions

Best Doctors®
CANADA INSURANCE SERVICES INC

INDEX

ART. 1

ACCEPTANCE OF THE INSURANCE

This insurance policy is arranged at Lloyd's underwriters (the 'Insurance Company'). The Insurance Company has issued this policy to insure the risk of, (see Summary of Benefits)_____
a Canadian corporation (Insured Entity).
This policy is effective as of (see Summary of Benefits)_____
The Insurance Company agrees to pay to the Insured Entity the benefits stated in this policy for any treatment, service or medical supply received by its employees and dependents anywhere in the world. All benefits are subject to the terms and conditions of this policy.

Ten (10) day right to examine the policy

The Insured Entity reserves the right to return this policy within ten (10) days after the receipt of the policy for a refund of all premiums paid, less any administrative fee paid per employee. The policy may be returned directly to the Insurance Company or to the Insured Entity's Agent. If returned, the policy is considered null and void as though no policy had been issued. If not returned within such ten (10) day period any refund requested will be processed, pursuant to article 10.9.

Important notice

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shown on the enrollment file is incorrect, incomplete, or if any information has been omitted, the policy may be rescinded, cancelled, or coverage may be modified, at the discretion of the Insurance Company.
Best Doctors Canada Insurance Services Inc. Global Medical Care™ 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 an insured person in Canada that would be covered for that person by the provincial health insurance plan or any government-sponsored program in the insured person's home province. The plan will cover expenses for enhanced services or supplies that Best Doctors Canada Insurance Services Inc. 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 your employee 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. 2

COMMENCEMENT, PERIOD 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 (USA) of the first (1st) of the month 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 (USA) of 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. 3

COVERED RISKS, ELIGIBILITY AND ENROLLMENT

3.1 Coverage for eligible employees:

The Insured Entity will receive coverage for employees that meet the following requirements:

a) Residing physically in a Canadian province or territory;
b) Are direct employees of the Insured Entity;
c) Are at least eighteen (18) years of age (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;

d) Any person described above shall be referred to in this policy as an “Eligible Person”.

3.2 Coverage for Eligible Dependents

a) Eligible dependents are an employee’s spouse, natural-born children, legally adopted children, stepchildren, or children to whom the employee has been appointed legal guardian by a court of competent jurisdiction;

b) Coverage for dependents remains in effect until the following policy anniversary date after having reached eighteen (18) years of age if single. Coverage for dependents older than eighteen (18) years of age may remain effective if they are full-time students at an accredited school and until the following policy anniversary date upon the dependent’s twenty-fourth (24th) birthday;

c) The Insurance Company reserves the right to request a student certification from the university or college in which the student is enrolled;

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

e) If the employee did not request coverage for a dependent when enrolled, the Insured Entity must submit proof of the dependent’s insurability in order to add dependents 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;

f) For newborn dependents 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 infant 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;

g) For adopted children, or those under guardianship or legal protection, legal documents establishing kinship are required;

h) Any person described above shall be referred to in this policy as an “Eligible Dependent”;

i) Any Eligible Person or Eligible Dependent described above shall be referred to in this policy as a “Covered Person”.

3.3 Enrollment

a) The Eligible Person must be a permanent employee and actively at work on a full-time basis;

b) Covered Persons will be automatically insured at open enrollment after the inception of the policy. The period for the open enrollment will be defined in the certificate of coverage of the policy;

c) New employees and their dependents will be insured only if the Insurance Company is notified during the first thirty (30) days of the employee joining the Insured Entity. If the Insured Entity does not notify the Insurance Company during this thirty (30) day period, the Insured Entity must submit the employee’s proof of insurability. For employees in an ineligible class who subsequently are promoted to an eligible class, the Insurance Company must be notified within 30 days of the date first eligible. If not, evidence of insurability is required;

d) If an employee is no longer employed by the Insured Entity, the Insured Entity’s coverage for the employee and their dependents will terminate on the same date of the event.

ART. 4

SUMMARY OF BENEFITS

Please see separate insert in the employee booklet.

ART. 5

DEDUCTIBLE RESPONSIBILITY

The deductible is indicated in the Summary of Benefits provided to each Covered Person. The amount described in the Summary of Benefits shall be referred to as a "Deductible".

5.1 One (1) deductible per Insured, 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.

5.2 If the deductible has been applied in the country of residence and medical services are rendered in the United States of America where the deductible is higher, the difference between the deductibles will be the Covered Person's responsibility.

ART. 6

POLICY PROVISIONS

6.1 **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.

6.2 **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.

6.3 **Benefits for unique services:** As an additional supplement, the Insurance Company provides to all of the Covered Persons access to the unique services arranged by the Insurance Company: "InterConsultation™" and "Elite Navigator™" delivered by Best Doctors Canada, Inc.

6.4 **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).

6.5 **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.).

6.6 **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 Tests 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.

6.7 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.

6.8 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 employees 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.

6.9 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.

6.10 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.

6.11 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), 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.

6.12 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.

6.13 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.

6.14 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.

6.15 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;
e) Those Covered Dependents, members 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.

6.16 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 6.15). 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 6.15) 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.

6.17 Travel Benefit: In the event treatment is sought more than 200 miles away from home and, said treatment is not readily available closer than the 200 miles, a travel benefit of up to $5,000 can be made available and may be used to pay for transportation (to and from point of service) and accommodation during the period in which said medical service is being performed.

ART. 7

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:

7.1 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.

7.2 Any care or treatment for illnesses or self-inflicted injuries, 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 the aforementioned criteria.

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

7.4 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 employee or dependent for employment or travel.

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

7.6 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.

7.7 Any expense related to pre-existing conditions as defined within this policy before the twenty-fourth (24th) month this policy has been outstanding.

7.8 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 (HPFB), Health Canada.

7.9 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.

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

7.11 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.

7.12 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.

7.13 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.

7.14 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**.**

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

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

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

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

7.19 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.

7.20 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.

7.21 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.

7.22 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.

7.23 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.

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

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

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

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

7.28 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.

7.29 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.

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

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

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

7.33 Any expense related to recreational or educational therapy.

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

7.35 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.

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

7.37 Best Doctors Global Medical Care insurance coverage does not provide payment or reimbursement indemnification for all or any part of the cost of any services or supplies performed for an insured 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 Best Doctors Canada Insurance Services Inc. 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.

7.38 Benefits in Canada for your employee 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. 8

HOW AND WHEN TO NOTIFY AND PRE-CERTIFY

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-Certification 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. 9

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:

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

9.2 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.

9.3 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 and 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. 10

ADMINISTRATION

10.1 Delivery of medical information to agent of record: The Insured Entity and its employees 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.

10.2 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.

10.3 Change of country of residence: The Insured Member must notify the Insurance Company in writing of any changes to the member'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 person who is changing his/her residence. Failure to notify the Insurance Company may result in cancellation of a person's eligibility.

10.4 Commencement of insurance: Benefits begin on the cover start date of the policy, subject to the provisions of this policy.

10.5 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.

10.6 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.

10.7 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.

10.8 Proof of claim: Reimbursement requests or claims related to medical services must be submitted to Best Doctors Canada Insurance Services c/o SCM International Programs Group LP, 120 Adelaide Street West, Toronto, ON M5H 1T1. 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.

10.9 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, up to a maximum of sixty-five percent (65%) of the premium. The policy fee and thirty-five percent (35%) of the base premium are nonrefundable. 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.

All policies are annual policies. No refunds are payable. The insured Entity must give thirty (30) days written notice prior to the anniversary date to effect the cancellation of coverage.

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

10.11 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.

10.12 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.

10.13 Policy cancellation or non-renewal: The Insurance Company retains the right to cancel the policy if the full annual premium 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 employees are found to be misrepresentations, incomplete or if fraud has been committed.

10.14 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.

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

10.16 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.

10.17 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.

10.18 Rate changes: Best Doctors Canada Insurance Services Inc. 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.

10.19 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.

10.20 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.

10.21 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.

10.22 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.

10.23 Arbitration, legal actions, and jury waiver: Any disagreement that may persist upon completion of the claims appeal as determined herein must first be submitted to arbitration under the National Arbitration Rules (ADR Institute of Canada). In such cases, the Insured and the Insurance Company will submit their differences to three (3) arbiters: each party selecting an arbiter, and the third arbiter to be selected by the arbiters named by the parties herein. In the event of any disagreement between the arbiters, the decision will rest with the majority. Either the Insured or the Insurance Company may initiate arbitration upon written notice to the other party demanding arbitration and naming its arbiter. The other party shall have twenty (20) days after receipt of said notice within which to designate its arbiter. The two (2) arbiters named by the parties, within ten (10) days thereafter, shall choose the third arbiter and the arbitration shall be held at the place hereinafter set forth ten (10) days after the appointment of the third arbiter. If the other party does not name its arbiter within twenty (20) days, the complaining party may designate the second arbiter and the other party shall not be aggrieved thereby. Arbitration shall take place in Toronto, Ontario, Canada. The expenses of the arbitration shall be shared equally between the parties. The Insured confers exclusive jurisdiction in Ontario for determination of

any rights and legal action arising directly from this policy. The Insured and the Insurance Company further agree to pay their respective costs and legal fees. The Insured and the Insurance Company waive any and all rights to a jury trial.

10.24 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.

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

10.26 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.

10.27 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. 11

DEFINITIONS

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

11.2 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.

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

11.4 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.

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

11.6 Applicant: The corporate group who signed the application for coverage.

11.7 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.

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

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

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

11.11 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.

11.12 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.

11.13 Country of residence: The country in which the Insured Member resides the majority of any calendar or policy year, or where the Insured Member has resided for more than one hundred and eighty (180) continuous days during any three hundred and sixty-five (365) day period while the policy is in effect. This policy covers Insured Members residing physically in a Canadian province or territory.

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

11.15 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.

11.16 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.

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

11.18 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.

11.19 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.

11.20 Durable medical equipment: Any medical equipment designed for continuous use. This includes, but is not limited to, wheel- chairs, hospital beds, respirators, and crutches.

11.21 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.

11.22 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.

11.23 Emergency treatment: Medically necessary treatment due to an emergency**.**

11.24 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), Health Canada or other federal agency of the government, whose approval is required regardless of the location where the medical charges are incurred.

11.25 Elite Navigator™: Through a simple phone call, your dedicated personal Physician Advocate will answer questions about your health, create a personalized wellness program, help you understand your lab tests and medical check-up results, deliver customized medical information, empower you to have more effective conversations with your own treating physician to ensure you receive the best possible care and provide the one-on-one support you need to navigate an often overwhelming healthcare system.

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

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

11.28 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.

11.29 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.

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

11.31 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.

11.32 Injury: Damage inflicted to the body.

11.33 InterConsultation™: An in-depth review of the eligible employee's medical records by Best Doctors for confirmation of the diagnosis and recommendation of the best treatment.

11.34 Insured Entity: The term "Insured Entity" refers to the corporation contracted under this policy.

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

11.36 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.

11.37 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.

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

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

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

11.41 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.

11.42 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.

11.43 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.

11.44 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.

Coverage of pre-existing conditions in the twenty-four (24) months prior to the policy start date are excluded from this contract. After twenty-four (24) months, the Covered Person would be covered regardless of whether the pre-existing condition was still present or not, unless otherwise excluded by this policy. For example, a person with Multiple Sclerosis would not have coverage for the first twenty-four (24) months of an issued policy, but the Covered Person could access the coverage commencing in the twenty-fifth (25th) month.

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

11.46 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.

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

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

11.49 Renewal date: The first day of the next policy year.

11.50 Rider: A document added to the policy by the Insurance Company which provides optional coverage.

11.51 Second surgical opinion: The medical opinion of a physician other than the current attending physician.

11.52 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.

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

11.54 Spouse: The individual with whom the employee is legally married, which is valid under the jurisdiction where such marriage took place or the individual living in a common law relationship with the employee for a continuous period of at least one (1) year and whom the employee has officially declared to be his or her spouse.

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

11.56 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 and Customary fees are defined by the Insurance Company's medical team.

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

For the purpose of the Insurance Companies Act (Canada), this Policy was issued in the course of Lloyd's Underwriters' insurance business in Canada.
Best Doctors insurances arranged at Lloyd's. Best Doctors Canada Insurance Services Lloyd's Coverholder. Underwritten by certain underwriters at Lloyd's.

Best Doctors
CANADA INSURANCE SERVICES INC