



Health Insurance
for New International Students
at University of British Columbia (UBC)



PLEASE READ THIS POLICY CAREFULLY

CONTACT THE 24-HOUR TOLL-FREE EMERGENCY ASSISTANCE NUMBER AT 1-800-995-1662 (NORTH AMERICA) OR COLLECT (416) 340-8444 FOR HOSPITAL ADMISSIONS, OR IF INCAPACITATED, AS SOON AS POSSIBLE.

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FREQUENTLY ASKED QUESTIONS

ELIGIBILITY

1. Will I need a medical examination to join the plan?

No, a medical examination is not required.

COVERAGE

1. Are pre-existing medical conditions covered?

Yes, pre-existing conditions are covered.

2. Can I seek treatment from a doctor or hospital of my choice?

Yes, we do not restrict you from using any legitimate, qualified medical provider or hospital. Should your treatment be required due to a medical emergency, please contact TIC Travel Insurance Coordinators for directions.

3. What happens if I am in a country where the appropriate treatment cannot be provided?

Once the treatment has been deemed medically necessary, TIC Travel Insurance Coordinators must be contacted and they will then make the necessary evacuation arrangements.

4. What do I do if the attending Medical Personnel do not speak my language?

Refer them to the TIC Travel Insurance Coordinators toll free number. TIC Travel Insurance Coordinators' multilingual staff will be able to communicate effectively on your behalf.

5. Does my coverage extend to include cosmetic surgery?

No, not if the surgery is elective. However, if the surgery is required because of an accident that occurred while you were insured, your policy will cover the costs.

LIFE EVENTS

1. Can I receive treatment when returning to my Home Country?

Coverage for a maximum of 90 consecutive days is available to Insured's permanently returning to their Home Country or Primary Place of Residency provided premium has been paid for this term.

CLAIMS

1. What is the deadline for submitting Medical claims?

All claims must be submitted no later than 365 days after the claim was incurred or 90 days after the termination of coverage whichever is earlier.

2. Where are my claims processed and paid?

All claims are processed at Norfolk Mobility Benefits Inc.'s global claim center located at:

300-999 8 Street S.W.
Calgary, Alberta, Canada T2T 1J5
Fax: +1 403 265-9425
claims@norfolkmobility.com

All documentation relating to the claim including the claim form and accounts must be provided. Copies of original documents will be accepted for amounts up to \$2,500 USD. The original receipts must be retained by the insured member for a period of 24 months from the date the claim was incurred during which time Norfolk Mobility Benefits may request these documents to validate

any claim at any time. In the event the original copy cannot be produced, the insured member will be responsible for any claim payments made in regards to that receipt.

3. How do I make a claim?

Claims should be submitted as per the guidelines outlined on pages 9 and 10.

4. Do claims need to be translated into English or converted into Canadian funds for processing?

No, Norfolk can process claims received in many different languages or currencies.

5. Do I have to provide a "Deposit" against my claim when I am admitted to the hospital?

This is not required unless requested by the service provider. If so, contact TIC Travel Insurance Coordinators in this regard.

Call Collect From Anywhere in the World
00 1 (416) 340-8444

6. Will the plan provide direct reimbursement to a hospital or medical provider?

On approval of the hospital or medical provider, direct reimbursement can be made.

You will be required to provide the hospital or provider's name, location, telephone and fax numbers so that arrangements can be made for direct payment as allowed by provider.

Pre-approval of Medical Treatment please email

NMBprecertification@norfolkmobility.com

Or

**Fax to the Attention of Precertification Department
(Canada) 001-403-265-9425**

7. What happens if I am hospitalized?

Contact TIC Travel Insurance Coordinators at the number shown on your I.D. card:

Call Collect From Anywhere in the World
00 1 (416) 340-8444

Please do not hesitate to contact Norfolk Mobility Benefits Inc. should you have any questions regarding your benefit program.

Norfolk Mobility Benefits' Client Service Centre

Phone: 00 1 (403) 537-8843

Toll Free: 1 (866) 767-5928 (within North America)

Email: clientservice@norfolkmobility.com

INSURING AGREEMENT

In consideration of the payment of the premium, the Insurer (various underwriters of Lloyd's of London), agrees with the policyholder to reimburse up to the limits detailed in this policy for costs incurred during the policy term subject to all of the exceptions, limitations and provisions of this policy.

Any word explained in the Definitions section herein will have the same meaning throughout this document. The currency of this policy is expressed in Canadian dollars (CAD).

GEOGRAPHICAL AREA OF COVERAGE

Worldwide

EFFECTIVE DATE AND POLICY TERM

This policy takes effect at 12:00 a.m., local standard time on the date stated in the application for coverage or the date coverage is approved by the Insurer and from which date all insurance months shall be calculated. It continues in force for the period for which premium has been paid. Coverage may be renewed subject to approval by the Insurer for further consecutive terms, not exceeding 12 months, on payment of premium at the rate and in the amount determined at the time of renewal by the Insurer.

ELIGIBILITY

For the purposes of this policy, Insured Persons shall be considered as those persons who:

1. Are enrolled as a student, on foreign assignment or travelling outside of their Home Country for an accredited educational facility;
2. Are eligible Dependents of the Insured as defined by this policy;
3. Are under age 65;
4. Have been enrolled under this Policy;
5. Have requested and received approval for extension of coverage upon termination of assignment and while traveling back to Home Country and have paid premium for this period or have had the premium paid on their behalf.

TERMINATION DATE OF INSURANCE

The insurance of an Insured Person shall terminate on the earliest of the following:

1. The date this policy is terminated;
2. The date that any premium required or due on the part of the Insured Person remains unpaid;
3. The date that the Insured Person reached age 65;
4. The date that the Insured Person no longer meets the Eligibility requirements as stated in the Policy or as approved by the Insurer;
5. The date the insured Dependent ceases to be an eligible Dependent as defined by this policy.

Termination of the insurance of any Insured Person will not prejudice consideration of any claim that may have occurred prior to such termination.

TERMINATION BY INSURED

Subject to approval by Plan Administrator (David Cummings Insurance Services Ltd.), the Insured may request termination of this contract by giving written notice of termination to the Plan Administrator acting on behalf of the Insurer, or by delivery thereof to an authorized agent (e.g. school or organization). If this Policy is cancelled prior to the Effective Date, the Insured will receive a full refund of premiums paid on a pro-rata basis.

If this Policy is cancelled after the Effective Date, the Insurer will refund the premiums paid subject to proof of existing equivalent coverage being in place. Refunds are subject to no claims having been incurred, paid, or pending. A waiting period of 90-days applies to all refunds.

OTHER INSURANCE

If, at the time of loss, the Insured Person has insurance from another source for Benefits provided under this policy, the policy with the earliest Effective Date will be deemed to be first payor. Any Benefits payable by the following shall not be considered as a covered cost under this policy:

1. Any group or individual Hospital or medical plan.
2. Any government Hospital or medical plan.
3. Any Worker's Compensation Act.
4. Any public or tax-supported agency.

DEFINITIONS

Accident: Any sudden and unforeseen event resulting in bodily Injury, the cause or one of the causes of which is external to the victim's own body and occurs beyond the victim's control.

For the purpose of the AD&D benefit insured under this policy please note the Accident must occur during the policy term.

Benefits: Any covered expenses/services that the Insurer will pay under this policy.

Benefit Maximum: The amount stated as the maximum payable for any particular Benefit per Policy Year, unless otherwise stated.

Complications Relating to Maternity Care: Complications are defined as any medical condition relating to pregnancy that if not immediately treated will threaten the life of the mother or unborn child.

Corrective Device: A device that is required by You on the advice of a Physician to correct a debilitating physical impairment and without which it would be a physical impossibility for You to continue Your studies or Your teaching responsibilities at the educational institution in which You are enrolled or are teaching. "Corrective Devices" include prosthetic limbs, wheelchairs, seeing-eye dogs, and hearing aids.

Couple Coverage: Coverage that includes the primary Insured member and an eligible spouse or eligible Dependent child, as defined by this policy.

Coverage Period: The period of time during which You are insured for the Benefits provided by this Policy, starting from 12:00 a.m. on the Effective Date until 11:59 p.m. on the latest of the date (a) specified as the Termination Date on the enrollment form; or (b) of termination of any extension of this Policy. The maximum Coverage Period including extensions is 365 consecutive days at any one time.

Coverage for a maximum of 90 consecutive days is available to Insured's permanently returning to their Home Country or Primary Place of Residency provided premium has been paid for this term.

Day Patient: A patient who occupies a Hospital bed or is charged for a Hospital bed.

Deductible: The dollar amount for which the Insured Person is liable, before any remaining eligible expenses are reimbursed under this policy.

Dependent:

1. The spouse or common law spouse (including same sex) of an Insured Person (but excluding those legally separated), and under the age of 65.

2. Unmarried children, step-children, foster children, legally adopted children and children under legal guardianship or custody, who are dependent on the Insured Person for support, provided that such children are not less than 15 days old and not more than 18 years old (or not more than 24 years old provided it can be proven that the child is continuing in full-time education).
3. Unmarried children, step-children, foster children and legally adopted children, who are dependent on the Insured Person for support due to physical or mental disability.

Diagnostic Services: Laboratory tests and x-ray services, radiographs and nuclear medicine procedures used to diagnose and treat medical conditions.

Effective Date: Means either

a) The date You arrive in the location of foreign study or assignment. In this case coverage is automatically provided to a maximum of 10 days while traveling to location of foreign study or assignment from Your Home Country or Primary Place of Residency; or

b) A later date as communicated by the Plan Administrator.

Emergency: A sudden and unexpected turn of events or change of condition which requires immediate medical treatment and which first manifests itself while this policy is in force as to the Insured Person.

Expatriate: A person who leaves his/her Home Country to reside in a foreign country for which he/she does not hold a valid passport.

Home Country: The country for which the Insured Person holds a passport. Where the Insured Person holds more than one passport, the Home Country will be taken to mean the country that the Insured Person has declared on the application form. Where a family is to be covered by the policy, there will be deemed to be one Home Country for that family, which will be the Home Country declared on the application form.

Hospital: Any medical or surgical institution which is legally licensed in the country in which it is located and whose main activities are not those of a rehabilitation centre, spa, hydro clinic, sanatorium, nursing home or home for the aged. It must be under the constant supervision of a resident Physician.

Hospital Services: Costs for accommodation, nursing, operating theatres, drugs, dressings, diagnostic procedures or any other necessary costs made by the Hospital for medical treatment.

Immediate Family Member: Refers to spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, brother-in-law, sister-in-law, father-in-law, mother-in-law, grandson, granddaughter, grandfather or grandmother of the Insured Person.

Injury: An unexpected and unforeseen harm to the body caused by an Accident resulting, directly and independently of all other causes, in the Insured Person incurring Medical Expenses.

Inpatient: A patient who occupies a Hospital bed for more than 24 hours for medical treatment and for which admission was recommended by a Physician or Surgeon.

Insured Person/You/Your: An eligible person as defined in the eligibility section of this policy.

Insurer: Certain underwriters at Lloyd's of London, England who provide this insurance.

Medical Appliances: Minor appliances such as crutches, casts, splints, canes, slings, trusses, braces,

orthotics and the temporary rental of a wheelchair when prescribed by a Physician or Surgeon.

Medical Assistance Provider: Travel Insurance Coordinators (TIC).

Medical Expenses: Those medical and related expenses for which coverage is provided under the Major Medical Benefits section of this policy which are necessarily incurred as a result of Injury or Sickness while coverage is in force under this policy as to the Insured Person.

Medically Necessary: Those services or supplies which are provided to You that are required to identify or treat Your Sickness or Injury and that are necessary for the relief of acute pain or suffering, or to identify or treat Your Sickness or Injury; or with respect to Hospital Services, those which cannot safely be provided to You as an Outpatient.

Norfolk Mobility Benefits Inc: The third party administrator and claims administrator appointed by the Insurer.

Outpatient: An Insured Person who receives treatment, including Diagnostic Services at a Hospital, or other medical institution, or at a Physician's office; where the Insured Person is not admitted or confined to a Hospital bed as an Inpatient or Day Patient.

Overall Maximum Limit: The total aggregate lifetime limit that may be claimed by an Insured Person. Such limit is indicated in the wording of this policy.

Physician or Surgeon: A legally licensed medical practitioner recognised by the law of the country where treatment is provided and who, in rendering such treatment, is practising within the scope of his/her licensing and training. A Physician or Surgeon must not be the Insured Person or an Immediate Family Member of an Insured Person.

Policy Year: the 12-month period beginning on the date the Primary Insured's coverage under the Policy commences. Subsequent Policy Years commence on the anniversary of that date.

Pre-Existing Condition: a Sickness or Injury which occurs prior to the effective date of coverage under this policy.

Primary Place of Residency: The location where the Insured maintains a permanent residence that is not located in the Home Country.

Reasonable and Customary Costs: Costs incurred for approved, eligible treatment or supplies that do not exceed the standard costs of other providers of similar standing in the same region, for the same treatment of a similar Sickness or Injury.

Sickness: Any illness or disease to the Insured Person which causes the Insured Person to incur Medical Expenses.

Termination Date: The date Your coverage under this Policy ends. Coverage ends on the latest of the date and time, (a) the date You request as the end date of Your application or (b) the date You permanently return to Your Home Country or (c) for Insured's permanently returning to their Home Country, a maximum of 90 consecutive days from the date of return provided premium has been paid to cover this period.

Well Baby Care: The customary Health Care services provided to a healthy newborn that are determined to be medically necessary, even though they are not provided as a result of illness, injury or congenital defect. This includes a series of regularly scheduled check ups, hearing loss assessments and immunizations. Please refer to the Medical Benefit for coverage and limitations.

GENERAL EXCLUSIONS

This policy does not cover expenses caused or contributed to directly or indirectly by:

1. Elective medical treatment;
2. Medication commonly available without a prescription; contraceptives, vitamin preparations; or medication received on a preventive basis that is not deemed medically necessary due to a pre-existing Sickness or Injury. This includes but is not limited to vaccinations and immunizations except as provided under the Well Baby Care provision of this policy;
3. The Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency HIV/AIDS Coverage Benefit, except as provided under the HIV/AIDS benefit;
4. Air travel, other than as a passenger in a certified commercial aircraft that provides passenger service and complies with government regulations concerning pilot licensing and current certificates of airworthiness;
5. Active participation in war or any act of war, or while participating in any armed forces training exercises or manoeuvre; radioactive contamination or committing or attempting to commit any criminal act;
6. Termination of pregnancy, except in the care of a major, vital complication which presents a clear and significant risk of death to the mother;
7. Mountaineering, scuba diving, rock or precipice climbing, hang gliding, paragliding, sport parachuting, sky diving, athletic or sports activities for remuneration or prize money, or while riding or driving in or on any motorised vehicle or device in any race of speed contents;
8. Intentional misuse of medication except as insured under the suicide clause of this policy, use of intoxicants or illegal drugs, or treatment thereof or Accidents related thereto;
9. Injuries received as a direct consequence or as a result of the Insured Person having blood content of more than 80 milligrams of alcohol per 100 millilitres of blood or, in the absence of a specific measurement, in the professional opinion of the attending Physician;
10. Any prescription medication classified as a Life Style drug;
11. Any claim arising from a trip or assignment undertaken outside the Home Country that has been arranged solely for the purpose of securing treatment or therapy unless it has been pre-approved by the Insurer.
12. Any Medical Expense incurred relating to a Pre-Existing Condition except:
 - o Medical Expenses that are medically recognized as standard for the maintenance or care of the Pre-Existing Condition or;
 - o Medical Expenses incurred in the treatment or stabilization of a Pre-Existing Condition resulting from a change in the Pre-Existing Condition.

In addition to the above, Benefits will not be payable for:

13. Examinations by, or the services of, a Physician if required solely for the use of a third party;
14. Traveling contrary to the medical advice of a Physician or Practitioner or for the purpose of obtaining Medical Treatment or when a terminal prognosis was given to the Insured prior to the Coverage Period;
15. Persons age 65 or over; and
16. Any costs incurred during any period for which the appropriate premium has not been paid or while the policy is not in force as to the Insured Person.

This policy also includes the following clauses / endorsements:

NUCLEAR, CHEMICAL, BIOLOGICAL TERRORISM EXCLUSION

Notwithstanding any provision to the contrary within this insurance or any endorsement thereto, it is agreed that this insurance excludes any losses, directly or indirectly arising out of, contributed to or caused by, or resulting from or in connection with any act of nuclear, chemical, biological terrorism (as defined below), regardless of any other cause or event contributing concurrently or in any other sequence to the loss.

For the purpose of this endorsement:

"Nuclear, chemical, biological terrorism" shall mean the use of any nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical agent and/or biological agent during the period of this insurance by any person or group(s) of persons, whether acting alone, 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 to put the public, or any section of the public, in fear.

"Chemical" agent shall mean any compound that, when suitably disseminated, produces incapacitating, damaging or lethal effects on people, animals, plants or material property.

"Biological" agent shall mean any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin (including genetically modified organisms and chemically synthesized toxins) which cause illness and/or death in humans, animals or plants.

Please refer to each Benefit description for additional exclusions.

MAJOR MEDICAL BENEFITS

Overall Maximum Limit

Notwithstanding the limits stated in the separate sections of this policy, the Overall Maximum Limit for Medical Expenses shall not exceed two million dollars (\$2,000,000) per insured, per lifetime.

Reimbursement is 100% of all eligible expenses with no Deductible.

Eligibility

All primary Insured members, their spouses and eligible Dependent children (as defined by this policy) are eligible for Medical coverage.

Hospital Benefits

When, by reason of Injury or Sickness, an Insured Person is confined to a Hospital, the Insurer will pay the Reasonable and Customary Costs for room and board charges (up to semi-private room accommodation), including the costs relating to Physicians, Surgeons, nursing, operating room, prescription drugs, dressings, Diagnostic Services, Medical Appliances, and any other necessary cost made by the Hospital for Inpatient Hospital Services, Day Patient Hospital Services, as well as costs incurred in an intensive care unit. **It is recommended that Insured Persons obtain pre-authorization from Norfolk Mobility Benefits Inc. or the Medical Assistance Provider.**

Physician's Fees

All Reasonable and Customary Charges made by a Physician for professional services or Medical Treatment.

Medical, Surgical and Diagnostic Services

When by reason of Injury or Sickness, an Insured Person incurs expenses for any of the following while under the regular care and attendance of a Physician or Surgeon, the Insurer will pay the Reasonable and Customary Costs incurred for the following:

1. **Corrective Devices.** A device that is required by You on the advice of Physician to correct a debilitating physical impairment and without which it would be a physical impossibility for You to continue Your studies or Your teaching responsibilities at the educational institution in which You are enrolled or are teaching. "Corrective Devices" include prosthetic limbs, wheelchairs, seeing-eye dogs, and hearing aids.
2. **Diagnostic, X-Ray, and Laboratory Services.** X-Ray or Laboratory examinations under the attendance or supervision of a Physician or Surgeon for Diagnostic Services. Laboratory and x-ray services must be provided by or ordered by a Physician. This policy does not cover magnetic resonance imaging (MRI), cardiac catheterisation, computerised axial tomography (CAT) scans for reasons considered Non-Emergency unless prescribed by a Physician.
3. **Prescription Medication.** Limited to a 60-day supply of any one type per Policy Year unless prescribed while a Hospital in-patient.
4. **Paramedical Services.** The services of a registered or certified massage therapist, chiropractor, physiotherapist, osteopath, naturopath, speech therapist, podiatrist or acupuncturist up to a maximum of \$1,000 per profession, per Policy Year per Insured.
5. **Psychiatric Care.** Up to \$25,000 for the services of a Psychiatrist while hospitalized as an Inpatient due to an emotional disorder. Psychologist, psychiatrist, counselor covered to a combined maximum of \$2,500 per Policy Year per Insured on Outpatient basis.
6. **Medical Equipment and Supplies.** (Payable only if required as the result of a covered Sickness

or Injury). Purchase of medical supplies, including dressings and prosthetic appliances. When required as the result of a covered Sickness or Injury only, up to \$350 for prescription glasses or contact lenses or up to \$500 for hearing aids. Rental charges for wheelchairs, crutches, Hospital-type bid or other appliances, not to exceed the purchase price.

7. **Private Duty Nursing Care.** Up to a \$5,000 lifetime maximum for the services of a Registered Nurse, Registered Nurse Assistant or Home Care Worker when ordered by the attending Physician.
8. **Emergency Transport.** The full cost of licensed ambulance service to the nearest Hospital when Medically Necessary. Emergency transfers between Hospitals when ordered by the attending Physician, including user fee; OR, taxi fare to or from a Hospital or medical clinic for eligible medical care to a maximum of \$100.
9. **Acute Dental Care.** Pays up to \$600 reimbursement per Emergency for the immediate relief of acute dental pain caused by other than a blow to the face. All treatment must be initiated within 48 hours from the time the Emergency began and must be completed no later than 90-days after treatment began assuming coverage is in force during the treatment period. Dental conditions for which the Insured has previously received treatment or advice are not covered.
10. **Emergency Dental Treatment.** When an accidental blow to the mouth or face results in Injury to an Insured Person, the Insurer will pay for the Emergency dental treatment necessary to restore or replace permanently attached artificial teeth or sound natural teeth lost or damaged in an Accident up to \$2,500 per Insured Person, per Injury. Emergency repairs to artificial teeth including bridges and denture plates are covered up to a maximum of \$500 per Insured Person, per Injury. Dental treatment must be initiated within 90 days following an Accident and completed within the policy term. Detailed medical documentation from a Physician or dentist must be provided to support an Insured Person's claim. Expenses incurred as a result of chewing Accidents or Injury due to placing an object to or in the mouth are not payable.
11. **Annual Physician Visit.** When a minimum of 6 months coverage has been purchased, Insurer will pay up to \$100 for one visit to a General Practitioner (Physician) during the Policy Year for a Non-Emergency exam and associated tests.
12. **Eye Exams.** Reasonable and Customary Charges for one Non-Emergency eye exam performed by a licensed Optometrist per 365-day period. Note: The costs of glasses or contact lenses are NOT covered unless required as per the Medical Equipment and Supplies Benefit, above.
13. **HIV/AIDS Coverage.** Expenses incurred as a result of a positive HIV, AIDS, or ARC diagnosis, which was diagnosed after coverage commenced, will be based on standard terms and conditions of the Policy and covered to a lifetime maximum of \$10,000, and these expenses will form a part of the Overall Maximum Limit.
14. **Maternity Coverage.** Maternity Coverage up to a combined maximum of \$25,000 for pre-natal care, childbirth, post-natal care, and newborn care (up to age 15 days). For newborn coverage past the age of 15 days, an application for dependant coverage must be made within 15 days. Emergency complications due to pregnancy are subject to the Overall Maximum Limit (\$2,000,000). Termination of pregnancy is not covered, except in the care of a major, vital

complication which presents a clear and significant risk of death to the mother.

Complications Relating to Maternity Care: Complications are defined as any medical condition relating to pregnancy that if not immediately treated will threaten the life of the mother or unborn child.

15. **Well Baby Care.** Includes a series of regularly scheduled check ups that begin in the first week after birth until the first month of life, subject to a maximum of two visits during this period. Hearing loss assessments and immunizations are also covered under Well Baby Care. Immunizations covered include the first dose of Hepatitis B and the dose for Tuberculosis for residents of developing countries.
16. **Suicide Clause:** This policy insures Medical Expenses incurred as a result of attempted suicide.

Your insurance also covers;

Trauma Counseling. If a Insured suffers a covered loss listed in the Schedule of losses, (other than loss of life) within 90 days from the date of an Accident which occurred during the Coverage Period, the Insurer will pay up to six sessions per lifetime of the Insured for trauma counseling by a registered Psychologist when ordered by the attending Physician.

Returning Insured Benefit. Coverage for a maximum 90 days is available to Insured's permanently returning to their Home Country provided premium has been paid for this period.

The following Benefits are covered with the prior approval from Your Medical Assistance Provider. The maximum amount payable for the following Transportation Benefits cannot exceed the Overall Maximum Limit.

1. **Air Evacuation.** The cost of transporting You to the nearest Hospital or to a Hospital in Your Home Country, if Medically Necessary, either:
 - a) as a stretcher fare in a regular flight, including economy return fares for qualified medical attendants (not a relative) and their associated fees and expenses; or
 - b) an appropriately equipped air ambulance, including associated fees and expenses for a qualified crew.Land ambulance costs at each end of the flight or connecting flights are included. The attending Physician must certify that the Insured is medically fit for the type of transfer selected.
2. **Family Transportation and Subsistence Allowance.** If You have no family members within 500 kilometers of Your location while You are outside Your Home Country and You are Hospitalized and Your Hospitalization is expected to last a minimum of 7 days or in the event of the death of the Insured. The Insurer will pay up to a combined lifetime maximum of \$7,500 towards the cost of round-trip transportation based on the lowest available fare for the most direct route for two (2) persons nominated by You to travel to Your bedside, as well as for commercial accommodation and meals for a maximum period of 7 days for these two (2) persons. The attending Physician must certify that the situation is serious enough to warrant the visit. Submit all bills and receipts to the Claim Administrator.
3. **Repatriation or Burial of Deceased.** If death occurs during the Coverage Period as a result of a covered Injury or Sickness, Insurer will pay either (a) up to \$12,500 towards the reasonable and necessary costs for the preparation and return of the Insured's remains to the Insured's Home

Country in a standard transportation container or (b) up to \$10,000 for the cost of preparing the remains, cremation or burial, and a burial plot in the location where death occurs. The costs for a coffin, urn, headstone or funeral are excluded.

4. **Return Home:** If in the event of Emergency Sickness or Injury of the Insured which necessitates the return home of the Insured for immediate medical attention, the Insurer will reimburse the actual extra cost of a one-way economy airfare by the most direct route, for the Insured to return to Insured's Home Country, to a lifetime maximum of \$5,000.
5. **Costs of Returning Home due to Family Emergency.** If the Insured must unexpectedly return Home due to the fact that an immediate member who is not traveling with the Insured has died, or is hospitalized for a serious illness, the Insurer will pay up to a lifetime maximum of \$2,500 towards the cost of round-trip transportation based on the lowest available fare for the most direct route to the location nearest the institution where the family member is being held. Insurer will also pay up to lifetime maximum of \$1,000 for commercial accommodation and meals for the Insured. This Return Home Benefit must occur within the Coverage Period.

Please refer to the General Exclusions section for Medical Exclusions and limitations.

**MEDICAL EMERGENCY ASSISTANCE
TRAVEL INSURANCE COORDINATORS (TIC)
Worldwide Emergency Coverage**

**In the event of Emergency Hospitalization please call:
TIC TRAVEL INSURANCE COORDINATORS
WORLDWIDE EMERGENCY ASSISTANCE
as soon as possible
1-800-995-1662
From Canada and the United States
011-416-340-8444
Collect to Canada
From anywhere else in the World**

In order to assist You in an Emergency situation, TIC will require the following information when You contact them.

1. Name of caller, telephone number and relationship to the patient.
2. Name of the patient, age, sex and location and their certificate number (if known).
3. Name of organization.
4. TIC Identification number (GFRW1244).
5. Nature of medical problem.
6. Telephone numbers of medical personnel involved.
7. How and when the next communication will take place.

In the event You are admitted to a hospital TIC must be notified immediately. They will take the appropriate action to assist You and monitor Your care until the situation is resolved – 24 hours a day, 7 days a week, 365 days a year.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) Benefits

The principal sum is a flat amount of \$50,000.

Eligibility

All primary Insured members are eligible for Accidental Death & Dismemberment coverage. Coverage is not available for spouses or Dependent children of the primary Insured member.

AGGREGATE LIMIT OF LIABILITY: \$10,000,000

The Insurer shall not be liable for any amount in excess of the above stated aggregate limit of liability.

If the aggregate amount of all indemnities otherwise payable by reason of coverage provided under this policy exceeds such aggregate limit of liability, the Insurer shall not be liable as respects each Insured for a greater proportion of the indemnity otherwise payable than the aggregate limit of liability bears to the aggregate amount of all such indemnities.

Coverage

Accidental Death, Dismemberment, Loss of Sight and Paralysis.

If such injuries shall result in any one of the following specific losses within one year from the date of Accident, the Insurer will pay the Benefit specified as applicable thereto, based upon the principal sum stated in the Insured Person's application, provided, however, that not more than one (the largest) of such Benefits shall be paid with respect to all injuries resulting from one Accident.

For the Loss of:	% of Principal Sum Payable
Life	100%
One Hand & One Foot	100%
One Hand or One Foot And the Sight of one Eye	100%
Both Hands or Both Feet or the Sight of Both Eyes	100%
Speech and Hearing in Both Ears	100%
Sight of One Eye	66 2/3%
Hearing in Both Ears	66 2/3%
Speech	66 2/3%
Thumb & Index Finger of Same Hand	33 1/3%
Hearing in One Ear	25%
Loss of Four Fingers of the Same Hand	33 1/3%
Loss of All Toes of the Same Foot	12 1/2%
Both Hands or Both Feet	100%
Both Arms or Both Legs	100%
One Arm or One Leg	75%
One Hand or One Foot	66 2/3%
Quadriplegia	100%
Paraplegia	100%
Hemiplegia	100%

"Loss" shall mean:

1. With respect to hand or foot, the actual severance through or above the wrist or ankle joint;
2. With respect to arm or leg, the actual severance through or above the elbow or knee joint;
3. With respect to eye, the total and irrecoverable loss of sight;
4. With respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree;

5. With respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid of device;
6. With respect to thumb and index finger, the actual severance through or above the first phalange;
7. With respect to fingers, the actual severance through or above the first phalange of all four fingers of the same hand;
8. With regard to toes, the actual severance of both phalanges of all toes of the same foot.

"Loss" as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs.

"Loss of use" shall mean the total and irrecoverable loss of function of an arm, hand or leg, provided such loss of function is continuous for twelve consecutive months and such loss of function is thereafter determined on evidence satisfactory to the Insurer to be permanent.

Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements and arising out of hazards described above shall be covered to the extent of the Benefits afforded an Insured Person.

If the body of an Insured Person has not been found within one year of the disappearance, stranding, sinking or wrecking of the conveyance in which the Insured Person was riding at the time of the Accident, it shall be presumed subject to all other conditions of the policy, that the Insured Person suffered loss of life resulting from bodily injuries sustained in the Accident and covered under this policy.

PROVISIONS – AD&D BENEFIT

Notice of Claim: Written notice of claim must be given to the Insurer within 30 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice by or on behalf of the claimant to the Insurer or to any authorised agent of the Insurer, with information sufficient to identify the Insured Person, shall be deemed notice to the Insurer.

Claim Forms: The Insurer, upon receipt of written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to the Insurer within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

Time of Payment of Claim: Indemnities payable under this policy will be paid immediately upon receipt of due written proof of such loss.

Payment of Claims: Indemnity for accidental loss of life will be payable to the beneficiary of record in a lump sum. The lump sum payment will be made immediately upon receipt of the required proofs of claim.

If, at the death of the Insured Person, there is no surviving beneficiary, the accidental loss of life indemnity shall be payable in one sum to the estate of the Insured Person.

All other indemnities will be payable to the Insured Person.

Physical Examinations and Autopsy: The Insurer at its own expense shall have the right and opportunity to examine the body of any Insured Person whose Injury is the basis of claim when and as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years (or the minimum time, if more than three years, permitted by law in the province where the Insured Person resides) after the time written proof of loss is required to be furnished.

Designation or Change of Beneficiary: Subject to any statutory restrictions, an eligible Insured Person may designate a beneficiary to receive death Benefits payable under this policy or may change any beneficiary already appointed, by filing written notice. No designation or change of beneficiary under the policy shall be binding upon the Insurer until the original or a duplicate thereof is received by the designated custodian or beneficiary records. No assignment of interest shall be binding upon the Insurer until the original or a copy thereof is received by the Insurer. The Insurer assumes to responsibility for the validity or legal sufficiency of such designation or change of beneficiary assignment.

Conformity with Provincial Statutes: Any provision of this policy which, on its Effective Date, is in conflict with the statutes of the province in which this policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such province.

Workers' Compensation Laws: This policy is not in lieu of and does not affect any requirements for coverage under any Workers' Compensation Law.

AD&D Exclusions and Limitations

1. AD&D coverage is not insured in the event of suicide.

Please refer to the General Exclusions section for additional exclusions and limitations.

HOW TO CLAIM

Help us provide the best possible claims service by making sure that all claim forms are accurate and complete. Supporting information should be attached where requested.

Claims must be submitted within the required time after the expense is incurred. Since mail delays can be extensive, all claims should be submitted as quickly as possible to:

Norfolk Mobility Benefits Inc.
300-999 8 Street S.W.
Calgary, Alberta, Canada T2T 1J5
Phone: 00 1 (403) 537-8843
Fax: 00 1 (403) 265-9425
Email: claims@norfolkmobility.com

Norfolk Mobility Benefits Inc. recommends that You retain a copy of the claim form and all receipts for Your records.

TIME LIMITS FOR SUBMITTING CLAIMS

It is important to note the time requirements for submitting claims. The following summary outlines these requirements.

Written proof of loss is required as follows:

• Accidental Death & Dismemberment (AD&D)	within 30 days after the claim was incurred
• Medical	within 365 days after the claim was incurred

In the event of a plan termination or an individual termination of the insured's coverage, all proofs of claim must reach the carrier no later than the time limits specified above, OR no later than 90 days after the date of termination, whichever is earlier.

SUBMISSION OF CLAIMS

HEALTH/MEDICAL CLAIMS

All documentation relating to the claim including the claim form and accounts must be provided. Copies of original documents will be accepted for amounts up to \$2,500 USD. The original receipts must be retained by the Insured Member for a period of 24 months from the date the claim was incurred during which time Norfolk Mobility Benefits may request these documents to validate any claim at any time. In the event the original copy cannot be produced, the Insured Member will be responsible for any claim payments made in regards to that receipt.

Hospital: Submit a Medical Claim Form plus a detailed receipt signed by the Hospital showing:

1. Name and address of Hospital;
2. Length of stay;
3. Type of accommodation;
4. Daily room and board charge;
5. Special charges by Hospital (e.g., drugs, x-rays, etc.);
6. Physician's charges (if any).

Medical treatment: Submit a Medical Claim Form. Applicable sections of the form are to be completed by the Insured. If the receipt does not include the following information, please have Your doctor complete the "Physician's Statement" section:

1. Description of Illness or Injury
2. Number of visits made
3. Total charge
4. Have the doctor PRINT his name and address, then date and sign the form
5. Attach original receipt from the doctor.

Prescription drugs: Submit a Medical Claim Form. Applicable sections of the form are to be completed by the Insured. The following information is required:

1. Name of drug or medication;
2. Charges made;
3. A dated receipt;
4. The form must then be signed by You and the total amount of the charges shown.

MEDICAL EMERGENCY EVACUATION

If medical treatment is required for an Emergency outside North America, the Insured, or someone acting on their behalf, MUST call the toll-free (or collect) number provided on the identification card. Immediate help is arranged and continued monitoring is provided during the Emergency. TIC representatives look after Hospital admission, referral to doctors, drugs,

ambulance, family transportation, airfares, attendant care, return and burial if death occurs. However, receipts should be kept for Emergency services that cost \$200 or less, and for expenses that exceed the specific allowances described in the evacuation policy. These should be submitted together with an authorized Medical Claim Form when the Insured returns home.

Emergency assistance must be arranged by calling TIC. Otherwise, Emergency evacuation (transport) expenses will not be eligible for reimbursement.

ACCIDENTAL DEATH & DISMEMBERMENT CLAIMS

Notify the Norfolk Mobility Benefits Inc. Administrator as quickly as possible. We will provide the appropriate forms.

METHOD OF REIMBURSEMENT

When sending in Your claim, please ensure that Your return address and contact information are clearly shown so we can contact You when necessary.

The conversion rate is determined on the date the claim is paid.

Claim reimbursement can be made using one of the following methods as selected at the time of claim or as information has been provided on the enrollment form.

The following claim payment options are currently available to You:

Benefit Cheque

A claim payment cheque will be mailed to the address provided on the claim form. All claim payments will be made in the currency of the policy or invoiced premium (CAD).

Wire Transfer

You may request that claims payment be wired into Your account anywhere in the world.

Norfolk Mobility Benefits will cover the costs of sending the wire payment, however, please note, it is common for receiving banks to charge You for the cost of receiving the wire transfer. This amount will be deducted from the claim payment and is the responsibility of the account holder.

Bank Drafts

It can be difficult or costly to deposit a CAD cheque in some countries. You may request a bank draft in local currency, which will be mailed to the address provided on the claim form. Bank drafts are subject to the availability of the requested currency. Please refer to the listing below for available currencies:

USD: United States Dollar
GBP: Great British Pounds
NZD: New Zealand Dollar
CHF: Swiss Franc
CAD: Canadian Dollar
HKD: Hong Kong Dollar
NOK: Norwegian Kroner
DKK: Danish Krone
INR: Indian Rupee
SGD: Singapore Dollar
EUR: Euro Dollar
MXN: Mexican Peso
SEK: Swedish Krona

Direct Deposit (EFT)

Claim payments sent overseas can be lost or delayed in the mail. To avoid this, You can request that claim payments are directly deposited to Your Canadian bank account. Bank accounts must be held within Canada. Please complete the appropriate section on the claim form and include a void cheque with Your claim, handwritten account numbers will not be accepted.

Banking information will be kept on file for future claim submissions. Please note, it is Your responsibility to notify Norfolk Mobility Benefits of any changes in banking information.

You may also elect to have a cheque sent directly to your bank to be deposited to Your Canadian or US bank account. Bank accounts must be held within Canada or the United States. Please complete the appropriate section on the claim form and include a void cheque with Your claim, handwritten account numbers will not be accepted.

GENERAL PROVISIONS AND LIMITATIONS

Arbitration: Any differences with respect to medical opinion will be settled between two medical experts appointed by the two parties. This dispute resolution will be in writing. Any differences of opinion between the two medical experts shall be referred to an umpire who shall have been appointed in writing at the outset by the two medical experts.

Automatic Continuation of Coverage: If the Insured is unavoidably delayed for a reason in no way attributable to the Insured, beyond the end of the Coverage Period, this Policy will automatically remain in effect at no extra premium for a period not to exceed:

1. 72 hours, if delayed while traveling as a fare paying passenger in a licensed public conveyance or by private vehicle and the delay is caused by mechanical breakdown, a traffic Accident or inclement weather; or
2. the period of confinement as an in-patient in a Hospital OR the period during which You are unable to travel on medical grounds acceptable to the Claim Administrator. Following discharge from Hospital or following medical approval to travel, an additional 72-hour extension will be granted.

Legal Proceedings: No legal proceedings shall be commenced until 60 days after a claim had been correctly submitted and no such action shall be brought unless commenced within three years from the first date of treatment.

This policy is governed by the Laws of Canada and the province of Alberta and any dispute arising out of this policy shall be settled in the courts of Alberta.

Misrepresentation and Fraud: All Benefits under this policy shall be voidable if the Insurer determines, whether before or after the loss, the Insured Person has concealed or misrepresented any material fact or circumstance concerning this policy or his/her interest therein, or in the case of fraud or false swearing by You or if You refuse to disclose information or permit the use of such information, pertaining to any of the Insured Persons under this policy. The completed and signed application form is the basis of and forms part of this policy and any erroneous responses therefore constitute material misrepresentation. Any claim to which any concealed or misrepresented material fact or circumstance pertain shall not be payable under this policy and You shall be solely responsible for all expenses relating to Your claim, including Emergency medical evacuation costs.

Payment of Benefits: The claims administrator will, on behalf of the Insurer, make payment to the Insured Person or legal representative or directly to the provider of treatment or services. Payment will be made in Canadian currency.

Policy Extensions: The maximum Coverage Period available under this Policy is 365 consecutive days from the Effective Date. Any request for policy extension must be made to the Plan Administrator prior to the Termination Date of Your existing coverage. Coverage

for this Policy extension will be void from inception if Your financial institution does not honor payment.

Insured's returning to their Home Country permanently can continue to be covered under the policy for a period of up to 90 consecutive days, provided the required premium is paid prior to the departure of the Insured Person. The Insurer shall have no liability for any claim incurred where the required premium has not been paid.

Pre-Authorization: It is recommended that Insured Persons obtain pre-authorization from Norfolk Mobility Benefits Inc. or the Medical Assistance Provider for all Inpatient and Day Patient Hospitalizations and special Outpatient Services.

Premium Payment: The full premium is due and payable when You apply for insurance. If for any reason the premium paid for the coverage applied for is incorrect, the Insurer will a) charge and collect the difference, or b) shorten the Coverage Period if an underpayment in premium cannot be collected, or c) refund any overpayment. Coverage will be null and void if for any reason the financial institution does not honor Your payment. The premium is calculated using the most current premium rates on the date You apply for coverage, and Your age and the Effective Date. We reserve the right to decline any application for insurance.

Refunds: Refunds are calculated on a pro-rata basis from the date postmarked on Your written request or on the date such fax or e-mail request is received by the Plan Administrator and is subject to a minimum refund amount of \$10.

Subrogation: If an Insured Person suffers a loss covered under this policy, the Insurer is granted the right from the Insured Person to take action to enforce all the rights, powers, privileges and remedies of the Insured Person, to the extent of Benefits paid under this policy, against any person or organisation which caused such loss. Additionally, if no fault Benefits or other collateral sources of payment of expenses are available to the Insured Person, regardless of fault, the Insurer is granted the right to make a demand for, and recover those Benefits. If the Insurer institutes an action, the Insurer may do so at its' own expense, in the Insured Person's name, and the Insured Person will attend at the place of loss to assist in the action. If the Insured Person institutes a demand or action for a covered loss he or she shall immediately notify the Insurer so that it may safeguard its' rights. The Insured Person shall take no action after a loss that will impair the rights of the Insurer.

Termination by Insurer of the Master Policy:

1. The Insurer may terminate at any time by giving a minimum of 90-days written notice of termination to the Insured.
2. The notice of termination may be mailed to the Insured, or sent by fax or email, or where another party or agent has sent the enrolment, that party or agent may be notified by mail, fax or e-mail.
3. Termination would be effective the end of the current term for which premium has been paid.

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

Waiver: The Insurer shall be deemed not to have waived any condition of this contract, either in whole or

in part, unless the waiver is clearly expressed in writing signed by the Insurer.

Statutory Conditions

The application, the policy, any document attached to the policy when issued, and any amendment to the contract agreed upon in writing after the policy is issued, constitute the entire contract. Any provision of the policy which, on its Effective Date, is in conflict with the statutes of the jurisdiction in which the policy was issued is hereby amended to conform to the minimum requirements of such statutes.

Identification of Insurer/Action Against Insurer

This insurance has been effected in accordance with the authorization granted to the undersigned by certain underwriters at Lloyd's, whose definitive members and proportions underwritten by them can be ascertained by references to this policy which bears the seal of Lloyd's Policy Signing Officer and has been certified by the Underwriter's Attorney In Fact in Canada and may be seen at the office of the undersigned. The underwriters identified in the said contract shall be liable hereunder each for his own part and not one for another in proportion to the several sums by each of them subscribed to the said contract.

ANNEX B – LLOYD’S POLICYHOLDERS’ COMPLAINT PROCEDURE

Should a policyholder wish to file a complaint relative to a Lloyd’s policy effected through a correspondent, the policyholder must be provided with the following Lloyd’s Complaint Protocol:

HOW TO MAKE A COMPLAINT

If You have a complaint with any aspect of Your Lloyd’s Insurance, please refer to the broker/agent who arranged Your policy for You.

If You are not satisfied, please submit Your written complaint to:

Lloyd’s Canada Inc.
Broker & Management Services
1155 rue Metcalfe, Suite 1540
Montreal, Quebec H3B 2V6

Tel: 1-877-4LLOYDS
Fax: (514) 861-0470
Email: lineage@lloyds.ca

Your written complaint will be forwarded to Lloyd’s Complaints Department in London, which ensures that Lloyd’s Underwriters and their representatives’ deal with claims and complaints in an acceptable manner. It acts as an impartial mediator. When undertaking a review, this Department takes account of general legal principles, good insurance practice, and whether all events surrounding a given case have been considered fairly.

RESIDENTS OF ONTARIO

You may avail Yourself of the services of the Insurance Ombudsman by requesting a letter from the broker/agent who arranged Your policy for You (stating their final position on Your complaint) and forwarding this letter along with Your written complaint to:

Insurance Ombudsman
Financial Services Commission of Ontario
Box 85, 5160 Yonge Street
North York, Ontario M2N 6L9
Fax: (416) 590-8480

PRIVACY GUIDELINES

At Norfolk Mobility Benefits Inc., we recognize and respect every individual’s right to privacy. When You apply for coverage or Benefits, we establish a confidential file of personal information.

We use the information to administer the group Benefit plan under which You are covered. This includes many tasks, such as:

1. Determining Your eligibility for coverage under the plan
2. Enrolling You for coverage
3. Assessing Your claims and providing you with payment
4. Managing Your claims
5. Verifying and auditing eligibility and claims
6. Underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
7. Preparing regulatory reports, such as tax slips

We limit access to information in Your file to Norfolk Mobility Benefits Inc. staff or persons authorized by Norfolk Mobility Benefits Inc. who require it to perform their duties, to persons to whom You have granted access, and to persons authorized by law. Norfolk Mobility Benefits Inc., Your health care provider, other insurance and reinsurance companies, and Your plan administrator may also exchange information when the information is needed to administer the group Benefit plan.