PRESTIGE TRAVEL PLAN WITH EXTENDED HEALTH CARE INSURANCE PLAN

CERTIFICATE OF INSURANCE

Insured by:

Administered by:

CERTIFICATE OF INSURANCE

PRESTIGE TRAVEL PLAN WITH EXTENDED HEALTH CARE INSURANCE
Insuring Members of

MUNICIPAL PENSION RETIREES' ASSOCIATION
(Called the Organization)

Group Master Policy 644464 has been issued to the **Municipal Pension Retirees' Association** hereinafter called the "Organization". An Insured Member of the Organization is referred to as the "Member." Desjardins Financial Security is referred to as "DFS."

The Group Policy is administered on behalf of DFS by the "Administrator" Johnson Inc. All transactions between the Policyholder, Member and DFS will be made through the Administrator. The Group Policy was delivered in the province of British Columbia, Canada, and is governed by the laws thereof.

The current Group Policy Year is September 1 through August 31. The Group Policy is renewable on each anniversary of the Policy Renewal Date subject to the policy terms and conditions.

This Certificate is issued to provide information in reference to a Member's personal insurance under the Group Policy and is subject to the terms, conditions, limitations of liability and exclusions stated in the Group Policy. If for any reason there is a discrepancy between this Certificate and the Group Policy, the provisions of the Group Policy shall prevail. The Group Policy is on file with the Policyholder, and upon request, it may be examined by the Member or the Member's personal representative at any reasonable time.

Only DFS is authorized to make changes to the Group Policy or this Certificate. Any changes to these documents will be made in writing over the signature of an executive officer of DFS.

This Certificate becomes effective on the later of June 1, 2016 or the effective date of the Member's insurance. It replaces all other Certificates and Certificate Riders, if any, previously issued to the Member under the Group Policy.

Desjardins
Insurance
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30 DAY RIGHT TO RETURN THIS CERTIFICATE

If for any reason the Member is not satisfied with this Certificate, the Member may return it to the Administrator within 30 days after the Member receives it. The Administrator will refund any premium paid and the Certificate will be deemed void, just as though it had not been issued, as long as no claims have been submitted.

PLEASE READ YOUR CERTIFICATE CAREFULLY

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BENEFIT SCHEDULE – PRESTIGE TRAVEL PLAN WITH EXTENDED HEALTH CARE

POLICYHOLDER	Municipal Pension Retirees' Association
POLICY NUMBER	644464
EFFECTIVE DATE	July 1, 2014
POLICY RENEWAL DATE	September 1 (annually)
DEDUCTIBLE AMOUNT	No Deductible

PRESTIGE TRAVEL PLAN (OUT-OF-PROVINCE/COUNTRY EMERGENCY TRAVEL COVERAGE)	
BENEFIT REIMBURSEMENT PERCENTAGE AND ANNUAL MAXIMUM BENEFITS PAYABLE	100% Reimbursement of Eligible Expenses.
BASE PLAN	The Base Plan is a continuous plan that provides Emergency travel coverage for an unlimited number of Trips, up to a maximum of 62 days duration for each Trip. Proof of Departure from Your province or territory of residence is required if a claim occurs.
SUPPLEMENTAL PLAN	The Insured Person may elect coverage under the Supplemental Plan for Trips of longer than 62 days up to a maximum of 212 days. This plan provides coverage for a single Trip occurring between the Effective Date and the Trip Termination Date as noted on the enrolment form or as subsequently advised to, and confirmed by, the plan administrator. The Insured Person must purchase a Supplemental policy in addition to the Base Plan to cover the entire length of his / her Trip.
LIFETIME MAXIMUM	$2,000,000 (Canadian Funds) per Insured Person.
PRIVATE DUTY NURSING	$5,000 per Calendar Year.
EMERGENCY DENTAL	$1,000 per Calendar Year.
PARAMEDICAL SERVICES	$225 per Calendar Year per Specialty for Chiropractor, Podiatrist/Chiropodist and Physiotherapist. Requires doctor referral and prior approval from Sigma Assistel.
TRIP CANCELLATION	Non-refundable portion of pre-paid travel arrangements up to $6,000 per Insured Person per Trip.
TRIP INTERRUPTION / DELAY	Extra cost of a one-way economy airfare to the departure of destination point and any unused non-refundable land arrangements to a maximum of $6,000 per Insured Person per Trip.
ADDITIONAL EXPENSES	$150 per day up to 10 days upon Trip delay due to hospitalization.

VEHICLE RETURN	**$2,000 for return of Vehicle per insured Trip.**
REPATRIATION	**$5,000.**

EXTENDED HEALTH CARE COVERAGE

BENEFIT REIMBURSEMENT PERCENTAGE	**80% Reimbursement of Eligible Expenses, unless otherwise specified.**
IN-PROVINCE MAXIMUM BENEFITS PAYABLE	**$250,000 lifetime maximum combined eligible drug and non-drug expenses per Insured Person.**
IN-PROVINCE ELIGIBLE EXPENSES	**As specified below and in the Description of Benefits Section.**

DIRECT PAY PRESCRIPTION DRUGS

PRIMARY PLAN
(Members with EHC coverage under the Pension Plan)

80% Reimbursement to the selected annual Household drug benefit maximum (MPRA Member covered for prescription drugs; non-drug EHC benefits available to Spouse and Dependent Children only):

PLAN 1: **If either You** OR **Your Spouse was born in 1939 or earlier, choose from two (2) Calendar Year maximums:**
- DRUG OPTION A: **$1,200 per Household***
- DRUG OPTION B: **$2,500 per Household***

PLAN 2: **If both You** AND **Your Spouse were born in 1940 or later, choose from two (2) Calendar Year maximums:**
- DRUG OPTION A: **$1,500 per Household***
- DRUG OPTION B: **$3,500 per Household***

**Annual Household maximum includes $850 of coverage for MPRA Member (reimbursed at 100%)*

Covers prescription drugs included in the BC Provincial Formulary (i.e. PharmaCare), subject to PharmaCare low cost alternative (LCA) and reference drug program (RDP) pricing, with a $10 dispensing fee cap and 8% mark-up limit.

ALTERNATE PLAN
(Members without EHC coverage under the Pension Plan)

80% Reimbursement of the first $1,500 of Your Household's out-of-pocket costs, then 100% coverage, to Your choice of two (2) Calendar Year maximums:

PLAN 1: **If either You** OR **Your Spouse was born in 1939 or earlier, choose from two (2) Calendar Year maximums:**
- DRUG OPTION A: **$1,200 per Household**
- DRUG OPTION B: **$2,500 per Household**

PLAN 2: **If both You** AND **Your Spouse were born in 1940 or later, choose from two (2) Calendar Year maximums:**
- DRUG OPTION A: **$1,500 per Household**
- DRUG OPTION B: **$3,500 per Household**

Covers prescription drugs included in the BC Provincial Formulary (i.e. PharmaCare), subject to PharmaCare low cost alternative (LCA) and reference drug program (RDP) pricing, with a $10 dispensing fee cap and 8% mark-up limit.

ACCIDENTAL DENTAL	**$1,000 per Calendar Year.**
AMBULANCE	**Ground Ambulance for medically necessary Emergency treatment. Any public Emergency transportation, including air ambulance, within the province, one (1) return trip per Calendar Year.**
DIAGNOSTIC SERVICES	**See Description of Benefits Section.**
HEARING AIDS	**$1,000 per five (5) Consecutive Calendar Years.**
HOME CARE BENEFIT	**$50 per day for up to 10 days following a 24-hour Hospital stay.**
HOSPITAL ACCOMMODATION	**100% Reimbursement up to $100 per day for private or semi-private accommodation.**
MEDICAL AIDS AND APPLIANCES	**Individual limits apply as illustrated in the Description of Benefits Section.**
PARAMEDICAL SERVICES	**$1,000 combined per Calendar Year:**
	▪ Acupuncturist; **▪ Athletic Therapist;** **▪ Chiropractor;** **▪ Massage Therapist (Physician recommendation required);** **▪ Naturopath;** **▪ Osteopath;** **▪ Physiotherapist;** **▪ Podiatrist / Chiropodist;** **▪ Psychologist; and,** **▪ Speech Therapist.**
PRESCRIBED HEALTH EDUCATIONAL PROGRAM	**$100 per Calendar Year for the Reimbursement of charges for wellness, rehabilitation and other medically related educational program(s) recommended by a Physician. This does not include fitness club fees and/or memberships.**
PRIVATE DUTY NURSING	**$3,000 per three (3) Consecutive Calendar Years.**
REFERRAL FOR TREATMENT	**See Description of Benefits Section.**
VISION CARE	**a) $300 per two (2) Consecutive Calendar Years for prescription lenses, eyeglasses, prescription sunglasses and contact lenses not covered in (b). $175 per person additional lifetime maximum for new lenses resulting from eye surgery.** **b) $200 per two (2) Consecutive Calendar Years for contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus (conical cornea), or aphakia provided visual acuity can be improved to at least 20/40.** **c) Visual training not covered by provincial health plan.** **d) One (1) ocular examination per two (2) Consecutive Calendar Years up to $100.**

DEFINITIONS

ADMINISTRATOR	**JOHNSON INC.** All transactions between the Policyholder and the Insured Person and/or a provider of service must be made through the Plan Administrator.
AGE LIMIT	Is not included except as it applies to the definition of Dependents.
ANNUAL	A Calendar Year.
BRACE	A rigid or semi-rigid supporting device or appliance which fits on and is attached to the body or any part of the body, excluding any dental brace which is used to correct a dental defect, deficiency or injury.
CALENDAR YEAR	The period starting January 1 and ending on December 31.
CLOSE BUSINESS ASSOCIATE	A person whose absence requires the Insured Person to return to the workplace to ensure no business or material deterioration in customer service or products, or impairment in the services provided.
COMMON CARRIER	Any land, air or water conveyance, which is licensed to carry passengers for compensation and is for hire.
COMPANY	**DESJARDINS FINANCIAL SECURITY (DFS)**.
CONFINEMENT OR CONFINED	Hospital confinement.
CONTRIBUTORY	The member has to pay part or all of the insurance premium.
COUPLE COVERAGE	Coverage for the Member and one (1) Eligible Dependent.
CURRENCY	Canadian currency unless otherwise stated.
DAY OF DEPARTURE	The date that the Insured Person exits their province or territory of residence in Canada.
DAY OF RETURN	The date that the Insured Person returns to their province or territory of residence in Canada.
DENTIST / DENTAL SURGEON	A person who is legally qualified and licensed to practice Dentistry in the jurisdiction where the services are rendered for which the charges are incurred.
DEPENDENT	Refer to definition of “Eligible Dependent”.
DRUGS AND MEDICINES	Medical preparations approved for use by Health and Welfare Canada (Food and Drug Act), and which by law must require written prescription by a Physician and which have been approved by the Company for Reimbursement under this Plan.
DUE PROOF	Written evidence of loss satisfactory to the Insurer.

ELIGIBLE DEPENDENT

DEPENDENT CHILDREN:

a) Natural children, legally adopted children or children living with the adopting parents during period of probation, stepchildren, children under legal guardianship, and foster children of the Member or the Member's Spouse. To be considered a Dependent, the child must be unmarried, not employed on a regular and full-time basis, and under 21 years of age. A child up to their 25th birthday will be considered a Dependent if in full-time attendance at an accredited school, college or university and dependent on the Member for support, including students attending school outside their normal Province of Residence; or

b) Mentally or physically handicapped children beyond any limiting age for Dependent children provided the child is incapable of self-sustaining employment and is wholly dependent upon the Member for support and maintenance.

SPOUSE / SURVIVING SPOUSE:

a) A person married to the member as a result of a valid civil or religious ceremony, including a person divorced or separated from the Member; or

b) A person, who although not legally married to the Member, cohabits with the member in a conjugal (including same sex) relationship that has been recognized as such in the community in which they reside.

ONLY ONE PERSON AT A TIME MAY BE COVERED AS A SPOUSE.

No person shall be eligible for coverage or covered under this agreement simultaneously as a Member and a Dependent of more than one insured Member.

ELIGIBLE EXPENSES FOR STUDENTS LIVING AWAY FROM HOME

Expenses for eligible Dependents studying outside their normal province of residence will be considered Extended Health Care, Eligible Expenses on the same basis as if expenses were incurred in their province of residence. Expenses incurred by students travelling 500 kilometres or more away from their student residence and outside their normal province of residence will be considered Out-of-Province/Country Emergency Travel Benefit Eligible Expenses. Eligible Dependents must be registered under their applicable provincial health care.

ELIGIBLE EXPENSES

Any expense incurred after the person's effective date of coverage under the Policy for any medically necessary, reasonable and customary item of expense listed in the Policy, of which by law can be covered in whole or in part and for which the Insured Person has made application, been approved by the Insurer and paid the premium.

ELIGIBILITY PERIOD

A period 60 days following the later of:

1. loss of employer benefits at retirement; or
2. loss of benefits from a spousal group plan or any other group plan.

Must be an MPRA member (Regular or Associate) and retain membership in good standing to participate in this plan as a Member.

EMERGENCY

Any sudden and unexpected Sickness or Injury which takes place during an insured trip and which requires immediate medical treatment by a licensed Physician, Nurse Practitioner, Dentist or Dental Surgeon. A Medical Emergency means an emergency service rendered to the Insured Person, Immediate Family Member of the insured, or Travelling Companion, for the

	sudden onset of a medical condition, manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could result in: a) permanently placing the individual's health in jeopardy; b) serious impairment and dysfunction of any bodily organ part; or c) other serious medical consequence. An Emergency ends when the Sickness and / or Injury has been treated such that the Insured Person's condition has stabilized or he / she is able to return to Canada with or without assistance. If the Insured Person opts not to return to Canada, further treatment for that Sickness or Injury or any complication arising from Sickness or Injury will not be covered. **INJURY**: Any bodily injury caused by an accident which occurs during a Trip and which results in a covered loss while this insurance is in force and which is serious enough to seek the attention of a licensed Physician, Dentist or Dental Surgeon (other than an Immediate Family Member). **SICKNESS**: Any sudden and unforeseen illness or disease that occurs during a Trip and while this insurance is in force and which is serious enough to seek the attention of a licensed Physician, Dentist, or Dental Surgeon (other than an Immediate Family Member).
EVIDENCE OF INSURABILITY	Evidence of the person's health that must be included with an Extended Health Care application when an application is submitted after the eligibility period or any other circumstance determined by the Company and which require approval by the Company to provide coverage to the applicant.
EXTENDED FAMILY MEMBER	An Insured Person's Spouse, parent, stepparent, child, guardian, grandparent, brother, sister, brother-in-law, sister-in-law, grandchild, parent-in-law, step-child, step-brother, step-sister, aunt, uncle, nephew, or niece.
FAMILY COVERAGE	Coverage for the Member and two (2) or more eligible Dependents.
GOVERNMENT PLAN	Any plan or arrangement provided by or under the administrative supervision of any government or agency thereof, which provides coverage or Reimbursement for any health care service or supply and without restricting the generality of the foregoing. This includes any Provincial Government Health Insurance Plan (GHIP), and comparable legislation in other jurisdictions.
GRACE PERIOD	The period that starts on the premium due date and continues for 31 consecutive days.
HOSPITAL	An institution operated pursuant to law for the care and treatment of sick and injured persons on an in-patient, outpatient and Emergency basis. While in Canada, this includes convalescent and rehabilitative hospitals (not homes). The Hospital must be continuously staffed and supervised by licensed Physicians and registered graduate nurses. Such institution must have facilities both for diagnosis and for major surgery. The term Hospital shall not include a rest home, nursing home, convalescent home, health spa, a place for custodial care, a home for the aged, and a chronic care facility or facilities.

HOSPITAL CHARGES	Charges made by a Hospital for room and board plus charges made by the Hospital for other necessary services and supplies furnished to the member or Dependent for his/her use while he/she is confined. Hospital charges shall not include charges for special nursing services or for services of Physicians and surgeons, or chronic care services within a Hospital.
HOUSEHOLD	All Insured Persons (Member and Eligible Dependents) in the immediate family.
ILLNESS	Any disorder of the body or mind, including pregnancy related disorders.
IMMEDIATE FAMILY MEMBER	A Spouse or Dependent as defined in the section "Eligible Dependent" in the Definitions section.
INJURY (EXTENDED HEALTH CARE)	Bodily injury caused by external, violent and accidental means.
IN-PROVINCE	The Insured Person's province of residence in Canada.
INSURED PERSON	A Member, Spouse or Dependent, as defined in this section, who is insured under this plan and for whom premium has been paid.
INSURER	**DESJARDINS FINANCIAL SECURITY (DFS)**.
LATE APPLICANT	A Member who applies for the Extended Health Care Plan after the Eligibility Period, or an Open Enrolment Period, unless otherwise stated in the Description of Benefits.
LICENSED, CERTIFIED OR REGISTERED	Licensed, certified or registered to practice the profession by the appropriate authority in the jurisdiction in which the care or services are rendered; or where no such authority exist, having a certificate of competency from the professional body which regulates the particular profession.
MEDICALLY NECESSARY	Broadly accepted by the medical profession as effective, appropriate and essential in the diagnosis and/or treatment of a sickness or injury, and based on generally recognized and accepted standards of health care.
MEMBER	An Insured Person in good standing with the **Municipal Pension Retirees' Association (MPRA)** who is a: 1. permanent resident of Canada covered by a Provincial Health Care Plan; and, 2. "Regular Member" of the **Municipal Pension Retirees' Association** is an individual receiving a pension or survivor's pension from the Municipal Pension Plan administered by the British Columbia Pension Corporation; or 3. "Associate Member" of the **Municipal Pension Retirees' Association** is an individual receiving any public sector pension or a spouse/partner not receiving a Municipal Pension.
NON-CONTRIBUTORY	The Policyholder pays all of the insurance premium.
ONGOING MEDICAL TREATMENT	Any treatment, service or consultation, which is deemed to be a continuation of, or provided subsequent to, Emergency medical treatment of a Sickness or Injury for which a claim was incurred.
OPEN ENROLMENT PERIOD	Period during which MPRA members can apply for coverage without providing evidence of insurability.

ORGANIZATION	**MUNICIPAL PENSION RETIREES' ASSOCIATION (MPRA)**.
OUT-OF-PROVINCE	Outside the Insured Person's province of residence.
PLAN ADMINISTRATOR	**JOHNSON INC.** All transactions between the Policyholder and the Insured Person and/or a provider of service must be made through the Plan Administrator.
POLICYHOLDER	**MUNICIPAL PENSION RETIREES' ASSOCIATION (MPRA)**.
POLICY YEAR	The period of time between any two (2) Policy Anniversaries.
PRACTITIONER OR PHYSICIAN	A person who is qualified and licensed to practice medicine or perform surgery within the scope and limitations of that license in the jurisdiction where the services are performed. The Practitioner/Physician will not include the member, nor the member's Spouse, children, brothers, sisters, or parents, nor any person residing in the Insured Member's household. Where permitted by law, the Travel Assistance Provider may approve the services of a Nurse Practitioner in substitution for appropriate and corresponding Physician services.
PROVINCIAL GOVERNMENT PLAN	The body of provincially enacted laws, as amended from time to time, governing provincial health insurance plans, provincial Hospital insurance plans, provincial medicare plans, provincial medical care and service acts, and other provincial government sponsored hospitalization, medicare, drug, or dental insurance plans which provide health insurance to residents of Canada.
REASONABLE AND CUSTOMARY CHARGE	A charge made by the provider of health care, services or supplies that does not exceed the general level of charges made by other providers of similar standing in the locality or geographical area where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individuals.
REGISTERED NURSE (R.N.), REGISTERED NURSING ASSISTANT (R.N.A.), LICENSED PRACTICAL NURSE (L.P.N.), OR A MEMBER OF THE VICTORIAN ORDER OF NURSES (V.O.N.)	A person who is licensed and qualified to perform nursing services within The scope of their license excluding a person who is a relative of the Insured Person, a homemaker, or a babysitter.
REIMBURSEMENT	The portion of the charge of an Eligible Expense that will be paid by the plan.
REMARRIAGE	Either of the following arrangements entered into by the surviving Spouse of a deceased member: 1. marriage by a valid civil or religious ceremony; or 2. a "common-law marriage" in which the surviving Spouse, who although not legally married to a person, cohabits with the person in a conjugal (including same sex) relationship which is recognized as such in the community where they reside.
SINGLE COVERAGE	Coverage for the member.
SPOUSE	Refer to definition of "Eligible Dependent".

TERRORISM	A violent act done in order to intimidate or terrorize the general public in the course of their daily lives for political ends, and does not include any act of war, civil commotion or civil unrest.
TRAVEL ASSISTANCE PROVIDER	**SIGMA ASSISTEL CANADA.**
TRAVEL SUPPLIER	A company in the business of providing transportation and accommodation arrangements to the public. This does not include a travel agent, agency, travel broker or tour company.
TRAVEL COMPANION	A person who accompanies an Insured Person on an insured Trip and who has prepaid accommodation and/or transportation arrangements with the Insured Person for the same insured Trip.
TRIP TERMINATION DATE	The earlier of: a) the date the Insured person returns to his / her province or territory of residence; or b) the date of return shown on the Insured Person's completed, signed enrollment form or the confirmation of coverage document; or c) The 212nd day after the Day of Departure (applies to the Supplemental Plan only).
TRIP(S)	Travel outside the Insured Person's province or territory of residence during which travel coverage is in effect. **EXCEPTION**: The Trip Cancellation or Interruption Benefit becomes effective on the later of the date the completed and signed enrollment form is received by Johnson Inc., or the date the Insured Person makes a deposit or full payment for a Trip booked in Canada.
TWO CONSECUTIVE CALENDAR YEARS	Two (2) Calendar Years beginning with the Calendar Year of Your last incurred claim.
TWO CONSECUTIVE YEARS	A 24-month period beginning from the date of Your last incurred claim and "three consecutive years" means a 36-month period, etc.
VEHICLE	A private automobile, motorcycle, van, trailer or self-propelled recreational vehicle either owned or rented by the Insured Person.
"YOU" OR "YOUR"	Refer to definition of "Member".

ALL TRANSACTIONS BETWEEN THE POLICYHOLDER, THE INSURED PERSON AND/OR A PROVIDER OF SERVICE MUST BE MADE THROUGH THE PLAN ADMINISTRATOR.

PRESTIGE TRAVEL PLAN (OUT-OF-PROVINCE / COUNTRY EMERGENCY TRAVEL) DETAILS

GENERAL PROVISIONS

1. MEMBER ELIGIBILITY

A Regular or Associate Member of the **MUNICIPAL PENSION RETIREES' ASSOCIATION (MPRA)** becomes eligible to be insured under this Plan on the date:

a) he/she becomes a Regular or Associate Member of the **MUNICIPAL PENSION RETIREES' ASSOCIATION**; and

b) his/her coverage under an employer-sponsored Group Insurance Plan terminates; or

c) his/her coverage under his/her Spouse's Group Insurance Plan terminates; or

d) his/her coverage under a Group Insurance Plan, other than those plans mentioned in b) and c) above, terminates

Application must be made on, before or within 60 days of the preceding dates, or during an Open Enrolment Period; otherwise the applicant will be deemed a Late Applicant and will be required to provide medical evidence satisfactory to the Insurer and must be approved by the Insurer for coverage.

2. DEPENDENT ELIGIBILITY

The insurance of an Eligible Dependent shall become effective on the later of:

a) the date the Member is first eligible;

b) the date the Member first makes written application for this insurance;

c) the date the Dependent's evidence of insurability is approved by the Insurer; or

d) the date the Dependent is no longer confined (excluding newborns).

If a member has Family Coverage under the policy, the Member is not required to make written application to insure additional Dependents, if no additional premium is required. Evidence of Insurability is required if the Dependent is a late applicant. If Evidence of Insurability is required and/or the Dependent is confined to a Hospital, the effective date of insurance shall be the first date the Dependent is not confined to a Hospital or the date insurance coverage is approved by the Insurer. In no event will the Dependent's insurance become effective before the Member's insurance becomes effective.

Confinement in a Hospital shall not postpone the effective date for:

a) a child born while the Member's Dependents are insured; or

b) a mentally or physically handicapped child of any age.

3. EFFECTIVE DATE OF COVERAGE

The insurance of eligible Member shall become effective on the later of:

a) If applying during the Eligibility Period, within 60 days of losing coverage under an employer group plan, Spouses' group plan or other group Extended Health plan, on the date the prior coverage terminated; or

b) If applying after the Eligibility Period, after 60 days of losing coverage under an employer group plan, Spouses' group plan or other group Extended Health plan, on the date the completed application is approved by the Insurer.

4. LATE APPLICANT

A Late Applicant, who applies after the Eligibility Period for the Prestige Travel Plan with Extended Health Care, or an Open Enrolment Period, will be required to provide medical evidence satisfactory to the Insurer and must be approved by the Insurer for coverage.

5. EXTENDED COVERAGE FOR DEPENDENTS

a) Coverage for Dependents of a Deceased Member.

Coverage for eligible Dependents shall continue following the death of the Member, provided premiums continue to be paid, until:

i) the date the policy terminates; or

ii) the Dependent's coverage otherwise would terminate under the other provisions of the policy.

b) Coverage upon Remarriage of a Deceased Member's Surviving Spouse.

Upon Remarriage of a Deceased Member's Surviving Spouse, the new Spouse and any Dependent children acquired, resulting from the remarriage will be eligible for coverage, subject to the Eligibility provisions for Dependents.

6. DUAL COVERAGE

Eligible children may be insured as Dependents of only one (1) Member even though both parents may be insured as eligible Members. A Spouse cannot be insured as a Dependent if also insured as a Member.

7. PREMIUM PAYMENTS

The premiums applicable to this insurance are payable one (1) month in advance on each premium due date. Premiums are paid by regular, interest-free monthly bank deductions as authorized on the application for benefits.

The premium stated for the Supplemental Trip Option Plan is the extra premium required for the specific Trip option chosen in excess of the 62-Day Base Plan. This premium is then divided into equal monthly payments, from the first premium deduction date following the purchase of the Supplemental Trip Option to the last premium deduction date in the policy year.

To request a cancellation and/or refund of premium, the following provisions apply. All requests must be made in writing to the Plan Administrator.

A refund and/or adjustment of premium is available under the Supplemental Travel Plan providing no Emergency Medical or Trip Interruption & Delay insurance claims have been made or are pending:

a) In the event of an early return from a Trip, proof of early return must be provided in the form of a

stamped passport, airline ticket or boarding pass, credit card receipt, border crossing slip, or any signed and dated document that proves You have returned to Your province or territory of residence; and

b) In the event that a situation covered under this insurance occurs which necessitates Trip Cancellation before Your day of departure, You may request a refund of premium or alternatively, a change in Your Supplemental Plan Trip dates by submitting a written request to Johnson Inc.

8. GRACE PERIOD

After the initial premium payment, each subsequent payment must be received within thirty-one (31) days after the premium due date, otherwise the Insured Person's coverage will be automatically terminated at the end of the grace period.

9. TERMINATION OF A MEMBER'S INSURANCE

Coverage for a Member under this plan shall terminate on the earliest of the following dates:

a) the date the plan is terminated by the Insurer or Policyholder;

b) the end of the month in which the Member requests in writing to terminate coverage;

c) the date the Member no longer makes premium payments, following the 31 day grace period;

d) the date the Member is no longer eligible for coverage;

e) the date the Member enters the Armed Forces of any country, state or international organization on a full-time basis; or

f) the date the Member dies.

10. TERMINATION OF A DEPENDENT'S INSURANCE

Coverage for a Dependent under this plan shall terminate on the earliest of the following dates:

a) the date the plan is terminated by the Insurer or Policyholder;

b) the end of the month in which the Member requests in writing to terminate Dependent coverage;

c) the date of termination of the Member's coverage, except that coverage may be continued in the event of the member's death in 5(a) Extended Coverage for Dependents of the general provisions;

d) the date the contributions to the cost of coverage are ceased;

e) the date the Dependent is no longer eligible for coverage;

f) the date coverage for Dependents is terminated as described under "Eligible Dependent" (i.e. attain age 21 or 25 for full-time students); or

g) the date the Dependent enters the Armed Forces of any country, state or international organization on a full-time basis.

11. REINSTATEMENT OF INSURANCE FOR NON-PAYMENT

If insurance is terminated for non-payment of premium, coverage can be resumed providing the outstanding and current premium owing is paid and provided that the insurance had not been terminated for more than three (3) consecutive months.

If insurance had been terminated for more than three (3) months due to non-payment of premium, the Member will be considered a Late Applicant.

12. AUTOMATIC 72 HOUR EXTENSION OF EMERGENCY TRAVEL COVERAGE

An Insured Person's Emergency Travel Coverage will be automatically extended beyond the first 62 days of travel coverage by the Extended Health Plan if:

a) Insured Person, a Travelling Companion, or an Immediate Family Member travelling with the Insured Person is hospitalized due to a medical Emergency on or before the 62nd day of travel, or the Trip Termination Date for Supplemental Coverage. Coverage will remain in force for as long as Insured Person, Travelling Companion, or Immediate Family Member is hospitalized plus an additional period of 72 hours following discharge from Hospital.

b) The period of insurance coverage is automatically extended for 72 hours when:

   i) The delay of a plane, bus, ship or train in which the Insured Person is a passenger causes him or her to miss his or her scheduled Date of Return to his or her province or territory of residence;

   ii) The personal means of transportation in which the Insured Person is travelling is involved in an accident or mechanical breakdown that prevents him or her from returning to his or her province or territory of residence; or

   iii) The Insured Person must delay his or her scheduled Date of Return to his or her province or territory of residence by the personal means of transportation in which he or she is travelling, due to extreme weather conditions.

13. INCONTESTABILITY

No statement made by You in Your application for insurance, except for fraudulent statements and omissions, shall be used by the Company to contest a claim after Your insurance has been in force for two (2) years following the policy issue date.

14. APPLICABLE LAW

Any provision of this policy which is in conflict with any federal, provincial or territorial law of the Insured Person's place of residence is amended to comply with the minimum requirements of that law. All other provisions shall remain in full force and effect.

15. NON-WAIVER PROVISIONS

Failure by the Company or the Plan Administrator to enforce any provision of this policy in a given circumstance shall not constitute a waiver of the right to enforce the provision at any other time. No one other than the Company has the authority to change or waive any provision of the policy.

16. LIMITATION OF LIABILITY

The Company or the Plan Administrator are not responsible for the availability, quality or results of any medical treatment or transportation, or the failure of an Insured Person to obtain medical treatment.

17. RIGHT OF EXAMINATION OF THE MASTER POLICY

An Insured Person and/or his or her personal representative shall, upon request, be permitted to examine this Master Policy, at the Plan Administrator's place of business or the head office of the Policyholder, for the purpose of ascertaining the benefits, terms and provisions of this agreement; provided that any such examination takes place during the normal business hours.

DESCRIPTION OF BENEFITS – PRESTIGE TRAVEL PLAN

If the Insured Person incurs charges for medically necessary treatment, services or supplies which are covered under the policy, the Company will pay benefits, subject to the terms, conditions and limitations outlined in the policy.

Benefits are payable to the extent that:

a) the charges are reasonable and customary for the services rendered and do not exceed the maximum amount specified;

b) there is no law or legislation prohibiting insuring such services in the Insured Person's province or territory of residence;

c) the services were authorized in writing as medically necessary by a Practitioner operating within the scope of his or her license except as otherwise stated;

d) the amount claimed is not covered, or exceeds the amount allowed under the Government Health Insurance Plan for the services provided; and

e) the charges are for treatment of a Sickness or Injury.

Under this policy, coverage for medical expenses is supplementary to and not a replacement for coverage under the Insured Person's Government Health Insurance Plan in their province or territory of residence.

Charges for the following services are included as Eligible Expenses for Reimbursement under Your policy:

EXTENDED HEALTH CARE EMERGENCY TRAVEL EXPENSES – OUT-OF-PROVINCE/COUNTRY COVERAGE

This plan is administered by Johnson Inc. (Johnson). It is underwritten by Desjardins Financial Security (DFS), which has appointed Sigma Assistel Canada Inc. (Sigma Assistel) as the sole provider of all assistance and claims services under this policy.

IMPORTANT: Benefits and services eligible for payment under this policy must be pre-approved and arranged in advance by Sigma Assistel. PLEASE READ THIS CERTIFICATE OF INSURANCE CAREFULLY.

Immediate contact to Sigma Assistel is necessary to ensure expenses are covered. At first onset of symptoms of a medical Emergency and before the Insured Person seeks medical attention, he / she should contact the 24-hour Sigma Assistel Assistance Centre; however if the Insured Person is unable to do so because he / she is medically incapacitated, someone else must contact Sigma Assistel as soon as is reasonably possible. Otherwise Eligible Expenses will be limited to $2,000.

1. PLAN DESIGN

BASE PLAN The Base Plan is a continuous plan that provides Emergency travel coverage for an unlimited number of Trips, up to a maximum of 62 days duration for each Trip. Proof of Departure from Your province or territory of residence is required if a claim occurs.

SUPPLEMENTAL PLAN The Insured Person may elect coverage under the Supplemental Plan for Trips of longer than 62 days. This plan provides coverage for a single Trip occurring between the Effective Date and the Trip Termination Date as noted on the enrollment form or as subsequently advised to, and confirmed by the plan administrator.

The choice of Plan is stated in the Confirmation Letter which is sent to an Insured on enrollment.

THE INSURED PERSON MUST PURCHASE A SUPPLEMENTAL POLICY IN ADDITION TO THE BASE PLAN TO COVER THE ENTIRE LENGTH OF HIS / HER TRIP.

EXTENDING YOUR TRIP If You have not had a medical condition and want to extend Your Trip, You must contact the Administrator to arrange for an extension of coverage before Your current Trip termination date. Your premium will be adjusted on the next monthly premium deduction date and written notification will be sent to You. If You have had a medical condition, the SIGMA Claims Assistance Centre must approve Your request for an extension.

2. BENEFITS

This policy of insurance, issued by DFS, covers reasonable and customary expenses incurred for medical treatment of a medical Emergency occurring during the Period of Coverage, and while the Insured Person is on an insured Trip. All dollar amounts stated herein are in Canadian currency unless otherwise stated.

DFS pays the Insured Person's health care provider or reimburses the Insured Person for covered expenses. DFS will in turn seek Reimbursement from the Insured Person's Government Health Insurance Plan and will co-ordinate coverage with other policies under which the Insured Person is covered according to the Co-ordinating Coverage Guidelines for Out-of-Province / Country Health Care Expenses.

This policy covers the following Eligible Expenses, and are subject to an overall lifetime maximum of $2,000,000 per Insured Person. Benefits/maximums indicated are on a **per Insured Person basis**, unless otherwise specified.

3. EMERGENCY MEDICAL EXPENSES

This benefit covers the cost of Emergency Hospital, surgical and medical treatment for the following:

a) Semi-Private Hospital room and board, or private room charges when a private room is certified as medically necessary by the attending Physician;

b) other Hospital services and supplies;

c) medical, surgical or anaesthetic treatment by a licensed Physician;

d) x-rays, lab charges and other diagnostic tests;

e) use of an operating room, anaesthetic and surgical dressings;

f) the cost of licensed ambulance service;

g) outpatient Emergency room charges;

h) drugs and medications legally requiring a Physician's written prescription; and

i) the rental cost of a wheelchair, or the rental or purchase of minor medical appliances such as crutches, braces and other necessary medical appliances.

4. TRANSPORTATION

Reimbursement of charges for:

a) licensed ground or air ambulance to the nearest medical care facility in which the required treatment can be provided, subject to a limit of one (1) return Trip;

b) extra costs of return economy fare by the most direct route (air, bus or train) to the insured's normal place of residence when an insured's illness is such that he/she must return home and be accompanied by a qualified medical attendant. Written authorization that such Emergency transportation and the care of a medical attendant is required must be provided by the attending Physician. Coverage includes:

    i) one (1) economy seat for the insured, or the number of economy seats required to accommodate the insured if the insured must be transported on a stretcher; and

    ii) one (1) economy round Trip fare for a medical attendant who is not related to the insured by blood or marriage.

c) one (1) round Trip economy fare (air, bus or train) by the most direct route from Canada, of an Insured Person's Immediate Family Member to be with the insured, who has been confined to a Hospital, when:

    i) the attendance of a family member is recommended in writing by the insured's attending Physician; and

    ii) the insured is confined to a Hospital for three (3) days or more.

d) one round Trip economy fare for an Immediate Family Member of the deceased Insured Person, by the most direct route (air, bus or train), when it is necessary to identify the deceased prior to the release of the body.

ALL TRANSPORTATION MUST BE PRE-APPROVED AND ARRANGED BY SIGMA ASSISTEL CANADA.

5. INCIDENTAL HOSPITAL EXPENSES

Eligible expenses up to a maximum of $100 per Hospital stay to cover incidental expenses for television rental and / or telephone rental provided the Insured Person has been hospitalized for 48 hours or more.

6. **PRIVATE DUTY NURSING EXPENSES**

Coverage will be provided to a maximum of $5,000 per Calendar Year for professional private duty nursing services (in Hospital only) by a registered graduate nurse (not related to the Insured Person by blood or marriage) when medically necessary and pre-approved by Sigma Assistel.

7. **PHYSIOTHERAPY AND OTHER PROFESSIONAL SERVICES**

When the professional services of a physiotherapist, chiropractor, chiropodist or podiatrist are medically necessary and the Insured Person's attending Physician verifies in writing that the treatment is necessary as a result of an Emergency, coverage will be provided for up to a maximum of $225 per Specialty per Calendar Year. Charges for these services will only be reimbursed after the Government Health Insurance Plan annual maximum has been reached for the corresponding type of professional service, where such legislation exists. Approval must be arranged in advance by Sigma Assistel.

8. **EMERGENCY DENTAL EXPENSES**

This benefit covers the reasonable and customary cost, up to a maximum benefit of $1,000 per Calendar Year, for repair or replacement of natural teeth (including capped or crowned teeth) or permanently attached artificial teeth (required as the result of an accidental Injury to the mouth caused by an external accidental blow to the mouth). Chewing accidents are not covered. Services must be performed by a licensed Dentist or Dental Surgeon.

To be eligible for payment for Emergency dental services,

a) expenses must commence within 30 days after the date of the Injury (unless the treatment cannot be rendered due to the nature of the Emergency), and the charges must be incurred within 365 days after such date;

b) the claim must be accompanied by one or more of the following: (i) an official police or accident report, (ii) a licensed Dentist, Dental surgeon or a Physician report, and / or (iii) an Emergency Hospital or medical facility report.

9. **EMERGENCY RELIEF OF DENTAL PAIN**

This benefit covers the cost of Emergency palliative treatment to relieve dental pain, up to a maximum of $200.

This benefit does not cover charges for routine dental care or treatment, root canal and other procedures which are not approved by Sigma Assistel. Services must be performed by a licensed Dentist / Dental Surgeon.

10. **RETURN OF MINOR DEPENDENT CHILD WITH ESCORT**

If a Dependent (as defined under Immediate Family Member) under the age of sixteen (16) who travels with the Insured Person on the same Trip is left unattended because the Insured Person is hospitalized for a period of 48 hours or more, or because the Insured Person must return to Canada because of a medical Emergency, this benefit will arrange for and cover the extra cost of one-way economy transportation by

the most direct route to return the Dependent to their home in their province or territory of residence. Coverage also provides for the cost of return economy transportation for an escort, when such escort is deemed necessary by the Insurer.

Benefits are only payable if this service is approved and arranged in advance by Sigma Assistel.

11. REPATRIATION OR BURIAL

If the Insured Person dies while on an insured Trip, this benefit will pay the cost of preparation (including cremation) and transportation of the deceased's remains to his / her province or territory of residence, or the cost of burial at the place of death up to a maximum of $5,000. The cost of a burial coffin or urn is not a covered expense.

12. VEHICLE RETURN

If neither the Insured Person nor a Travelling Companion is able to operate the Insured Person's owned or rental Vehicle due to Sickness, Injury or Death while travelling outside the Insured Person's province or territory of residence, this plan will reimburse a maximum of $2,000 per Household for the return of the Vehicle per Trip. Eligible for Reimbursement is the cost of the return performed by a professional agency; or the following necessary and reasonable expenses incurred by an individual returning the vehicle on behalf of the Insured Person: fuel, meals, overnight accommodation, one-way economy airfare. **TO RECEIVE REIMBURSEMENT, ORIGINAL RECEIPTS MUST BE SUBMITTED.** Any other expenses are not covered.

Expenses incurred by anyone travelling with the person returning the vehicle are not covered.

Benefits will only be payable for return of the Vehicle when the service is pre-approved and / or arranged by Sigma Assistel and the vehicle is returned to the Insured Person's normal place of residence or the nearest appropriate rental agency within 30 days of the Insured Person's return to Canada.

13. TRIP CANCELLATION, INTERRUPTION AND DELAY BENEFITS

This insurance does not cover Trips within the Insured Person's province or territory of residence and must be in effect prior to the event which necessitates a claim. When the reason for cancellation occurs prior to departure of an insured Trip, the Insured Person must cancel his / her Trip with the travel agency or Travel Supplier and notify Sigma Assistel Canada within 48 hours following the event forcing cancellation. Any issued ticket(s) must be surrendered to Sigma Assistel Canada. Please Note: Any loss arising as a result of the bankruptcy or insolvency of a travel agent, agency, broker or travel supplier is not covered.

In the event the Insured Person must cancel his / her Trip, the Insured Person will be reimbursed the non-refundable portion of the pre-paid travel arrangements up to a maximum of $6,000 per Trip.

TRIP INTERRUPTION AND DELAY—POST DEPARTURE

In the event the Insured Person must curtail his / her Trip or delay his / her Day of Return, the Insured Person must contact Sigma Assistel Canada within 48 hours of the event forcing interruption / delay. The Insured Person will be reimbursed for the extra cost of a one-way economy airfare to the departure point

or to the destination point and any unused non-refundable land arrangements up to a maximum $6,000 per Trip.

Trip Cancellation, Interruption and Delay benefits are covered where applicable upon the occurrence of any of the following events:

a) Death, Injury or Sickness of an Insured Person, an Extended Family Member, a Close Business Associate, or a Travelling Companion.

b) Insured Person being called unexpectedly for jury duty or being subpoenaed as a witness in a case being heard during the Trip.

c) A transfer by employer of the Insured Person or his / her Spouse for which notice was received from the employer subsequent to the booking and prior to scheduled Day of Departure, if the date of transfer is coincident with or prior to the scheduled Day of Departure, and requires a move to a new principal residence.

d) Damage to the Insured Person's principal residence by a disaster making it uninhabitable.

e) Hijack of a Common Carrier in which an Insured Person is travelling.

f) Terrorism in a country that an Insured Person is scheduled to visit, which leads to a recommendation by the Government of Canada that Canadians should not travel to that area due to Terrorist incidents for a period which includes the Day of Departure.

g) Death, quarantine or hospitalization for at least 48 hours, of host at destination.

h) A natural disaster at the place of destination.

i) Medical quarantine of an Insured Person for a communicable disease diagnosed by a Physician.

j) If an Insured Person is involuntarily dismissed or laid-off from his / her principal employment within 30 days of the scheduled Day of Departure, provided a letter of termination is produced, and provided the Insured Person had no knowledge of this loss on the date of application for insurance.

k) Refusal of an Insured Person's visa, provided that documentation shows he or she was eligible to apply, that refusal is not due to a late application, and that the application is not a subsequent attempt for a visa that had been previously refused.

l) If the Insured Person misses the originating flight from the scheduled departure point or cruise due to delay of the Insured Person's connecting carrier (plane, ship, bus, limo, taxi, train, auto) resulting from inclement weather conditions, mechanical failure, traffic accident, police-directed road closure or flight delay.

m) Cancellation of a planned business meeting due to death or hospitalization of the person with whom the Insured Person is to meet, or cancellation of a conference (for which the Insured Person has paid registration fees) due to circumstances beyond the control of the Insured Person. Benefits are only payable to the Insured Person who is attending the meeting. Proof of registration will be required in the event of a claim.

n) A call to service of the Insured Person by Government with respect to reservists, military, police or fire personnel.

Expenses will be reimbursed when the Insured Person provides, at DFS's discretion, any of the following when applicable:

a) a statement completed by the Physician in personal attendance in the locality where the Sickness or Injury occurred stating the diagnosis and the complete reason for the necessity of delay or cancellation of the Insured Person's Trip;

b) documentary evidence of the Emergency situation which caused the delay;

c) proof that a portion of the travel arrangement costs are non-refundable;

d) any unused transportation tickets;

e) any receipts for land arrangements and out-of-pocket expenses,

f) any tickets or receipts for any extra transportation cost incurred.

EXCLUSION: TRIP INTERRUPTION AND DELAY

Benefits will not be payable for an early or late return (a return Trip delayed more than 10 days beyond the scheduled Day of Return) unless recommended by the attending Physician; or the Insured Person was incapacitated, or the Immediate Family Member, Travelling Companion, or Close Business Associate of an Insured Person was confined to a Hospital for at least 72 consecutive hours within the 10-day period.

Any loss arising as a result of the bankruptcy or insolvency of a travel agent, agency, broker or travel supplier is not covered.

Any loss arising from work stoppage or airline strike of a travel supplier is not covered.

Points Program redemptions of any type and points used to purchase travel arrangements are not an eligible expense under this insurance. Please contact Your Points Program supplier. Exception: If there is any monetary fee charged for the reinstatement of Your applicable travel points, Reimbursement may be payable based on the covered events listed under Trip Cancellation, Interruption & Delay Insurance benefits.

14. ADDITIONAL HOTEL AND MEAL EXPENSES

This benefit covers the cost of necessary meals and hotel accommodation up to $150 per day and up to a maximum of $1,500 per person for the following:

a) Transportation to the Bedside, and

b) Trip Interruption and Delay, and

c) Return of Minor Dependent Child (under the age of 16) with Escort.

SIGMA ASSISTEL TRAVEL ASSIST SERVICE

In an Emergency, the Insured Person or someone on their behalf must contact Sigma Assistel to ensure the Insured Person's expenses are covered. At the first onset of symptoms of an Emergency, and before the Insured Person seeks medical attention, he / she must contact the 24-hour Sigma Assistel Centre. If the Insured Person is unable to do so, because he / she is medically incapacitated, someone else must contact Sigma Assistel as soon as is reasonably possible.

This call to the Sigma Assistel Emergency Assistance Helpline will entitle the Insured Person to receive the following services:

1. **MEDICAL ASSISTANCE AND CONSULTATION**

   The Insured Person will be directed to the nearest appropriate medical facility. Sigma Assistel will verify coverage to ensure there are no delays in treatment.

2. **UP FRONT PAYMENT**

   For eligible medical expenses, Sigma Assistel will guarantee coverage and arrange direct payment to the medical providers and the Hospital, wherever possible.

3. **EMERGENCY MESSAGE CENTRE**

   In case of an Emergency, Sigma Assistel can help to relay important messages to or from the Insured Person's family, business or Physician.

4. **LOST DOCUMENT AND TICKET REPLACEMENT**

   Sigma Assistel will help the Insured Person replace lost or stolen travel documents. The cost of obtaining replacement documents is the Insured Person's responsibility.

5. **LEGAL ASSISTANCE**

   Sigma Assistel can direct the Insured Person to a local lawyer or assist the Insured Person to arrange for bail or for payment of legal fees. The cost of these services is the Insured Person's responsibility.

6. **PRE-TRIP PLANNING ASSISTANCE**

   If the Insured Person calls 1-877-775-3695 Sigma Assistel can provide information on inoculation and visa requirements.

PRE-EXISTING CONDITIONS

Pre-existing conditions are not a limitation under this policy, in which case, any Eligible Expenses related to a pre-existing condition will be reimbursed at 100%.

CLAIMS

1. NOTICE AND PROOF OF CLAIM FOR EMERGENCY TRAVEL COVERAGE

In the event of a Medical Emergency, Sigma Assistel will direct the Insured Person to the nearest appropriate medical facility. Sigma Assistel will pay Hospitals and other medical providers directly, wherever possible, except when the Insured Person chooses to pay the expenses or when the medical care provider refuses to accept payment directly from Sigma Assistel. To ensure expenses are covered and to benefit from the assistance services available, the Insured Person must notify Sigma Assistel when he / she has an Emergency and preferably before hospitalization, or within 48 hours after admission to a Hospital. If the Insured Person is unable to do so because he /she is medically incapacitated, someone else must do so as soon as is reasonably possible. Otherwise Eligible Expenses will be limited to $2,000.

To make a claim for Emergency Travel expenses under this policy, notice of the claim must be submitted to Sigma Assistel within thirty (30) days after the Medical Emergency occurs, or as soon as is reasonably possible thereafter. A phone call to Sigma Assistel to report the claim will be considered "Notice of Claim" under the terms of the policy.

Within 90 days after the date of the medical *emergency*, but not more than 12 months after the date of the medical *emergency* you must submit written proof of claim, which includes:

a) Completion of any claim forms furnished by Sigma Assistel,

b) Original itemized receipts which include the physician's name and credentials, the attending physician's report or statement, and any other form of documented evidence requested by Sigma Assistel.

If the claim is reported by telephone to ***Sigma Assistel***, and the medical service provider agrees to bill ***Sigma Assistel*** directly for the *eligible expenses*, Sigma Assistel will, where possible, obtain the documentation necessary to process the claim. Incomplete or incorrect claim forms will be returned and may delay the claim processing. If, for any reason, *you* arrange treatment and pay the *eligible expenses*, *you* must provide supporting documentation as indicated above. *You* are responsible for any expenses incurred for any necessary documents required for the purpose of adjudicating a claim.

All documents necessary to support a claim must be provided to Desjardins Financial Security and / or Sigma Assistel Canada at the Insured Person's expense.

On termination of an Insured Person's coverage for any reason, including as a result of termination of this policy, written proof of claim satisfactory to the Plan Administrator must be received no later than 90 days following the date of termination.

Failure to give notice of claim or furnish proof of claim within the time prescribed herein does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date a claim arises hereunder, if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

2. CO-ORDINATION OF BENEFITS BETWEEN TWO PLANS

Benefits payable under this policy shall be co-ordinated with any other coverage(s) and are payable in excess of all other benefits in effect on the Insured Person's behalf, so that payment under this policy and any other plan, including but not limited to the Insured Person's Government Health Insurance Plan, individual or group policy, credit card coverage or other insurance, shall not exceed 100% of the eligible charges incurred.

3. RIGHT TO RECOVER PAYMENTS

If after benefit payments have been made to or on behalf of any Insured Person, it is discovered that, due to clerical, electronic or administrative error, payment was made inadvertently or in excess of the amount(s) required to satisfy the terms of this policy, the Company reserves the right to recover the inadvertent or excess payment(s) from the Insured Person or to the organization to whom the payment was paid.

If the amount of the inadvertent or excess payment(s) cannot be recovered within a reasonable time period, the Company has the right to reduce future benefit payments to or on behalf of the Insured Person until such amount(s) are recovered in full.

4. SUBROGATION FROM A THIRD PARTY

If the Company pays any benefits in respect of a sickness or injury where a third party is liable, the Insured Person's right of recovery shall be subrogated to the Company to the extent of the benefits paid, and the Company may bring action in the name of the Insured Person to enforce such right where permitted by law.

In such an event, the Insured Person and his/her legal representative shall co-operate with the Company to facilitate recovery and settlement of any payments, in order to satisfy the intent of this provision.

5. AUTHORIZATION

An Insured Person as a condition precedent to receiving benefits under this agreement, consents to, authorizes and directs any person or corporation to provide the Plan Administrator with any reports, records, x-rays or other information relating to the treatment, services or supplies for which the claim is made.

6. LIMITATION OF ACTION

In the event of a claims dispute, an Insured Person must bring any legal action or proceeding against the Company within 24 months of the date the charges were incurred or the date on which they return to their province or territory of residence, whichever applies. All legal actions or proceedings must be brought in the Canadian province or territory in which the Insured Person permanently resides.

7. DUPLICATE COVERAGE

If there is any duplication of expenses between both In-Province Extended Health Care and Prestige Travel Plan Eligible Expenses, expenses which are incurred outside the insured individual's province or residence in the event of an Emergency while travelling shall be payable as Prestige Travel Plan Eligible Expenses, not as In-Province Extended Health Care Eligible Expenses.

8. RETURNING A PATIENT TO THEIR PROVINCE OF RESIDENCE

The Company, through Sigma Assistel, in consultation with the attending Physician, reserves the right to return the sick or injured Insured Person to his or her province or territory of residence. If in consultation with the attending Physician, an Insured Person is able to return to their province or territory of residence following the diagnosis of, or Emergency medical treatment and / or diagnosis of a medical condition which requires continuing medical care, treatment or surgery, and the Insured Person elects to have the treatment or surgery performed outside their province of residence, no benefits shall be payable with respect to such continuing treatment or surgery. The immediate availability of treatment or surgery on return to the province of residence is not the responsibility of the Company, Sigma Assistel or the Plan Administrator.

9. PROOF OF DAY OF DEPARTURE

In the event of a claim, the Insured Person will be required to provide proof of the Day of Departure from his / her province or territory of residence.

Proof of Day of Departure includes: a border crossing receipt, duty free receipt, airplane ticket or boarding pass, stamped passport, credit card receipt, signed and dated bank or financial institution documents, or any signed and dated document that proves the Insured Person was in his / her province of residence the day before the schedule Day of Departure.

Proof must identify the following:

a) Your name;

b) transaction date; and,

c) transaction location.

10. CONTACT IN THE EVENT OF A MEDICAL EMERGENCY

The Insured person must contact Sigma Assistel directly when a medical Emergency arises, at their 24-hour Emergency Helpline:

SIGMA ASSISTEL
Canada/USA: 1-877-775-3695
Other Locations (Call Collect): (514) 875-3695
Fax: (514) 875-7729

Sigma Assistel will direct the Insured Person to the nearest appropriate medical facility. Sigma Assistel will pay Hospitals and other medical providers directly, wherever possible, except when the Insured Person chooses to pay the expenses or when the medical care provider refuses to accept payment directly from Sigma Assistel.

IMPORTANT TO REMEMBER!

To benefit from the assistance services available and to ensure expenses are covered, the Insured Person must notify Sigma Assistel when he / she has an Emergency and preferably before hospitalization or within 48 hours after admission to a Hospital. If the Insured Person is unable to do so because he / she is medically incapacitated, someone else must do so as soon as is reasonably possible. Otherwise Eligible Expenses will be limited to $2,000.

EXCLUSIONS AND LIMITATIONS

EMERGENCY TRAVEL ELIGIBLE EXPENSES SHALL NOT INCLUDE CHARGES FOR:

Exclusions applicable to the Extended Health Care Benefit also apply to the Prestige Travel Plan. Furthermore, the Insurer will not pay any of the benefits provided for under the Prestige Travel Plan in the following circumstances:

1. expenses are not incurred as a result of a sudden and unforeseen “Emergency” or “Medical Emergency” as defined in this certificate, while travelling outside the province of residence or outside Canada;
2. for elective, non-Emergency treatment or surgery, when this service could have been provided in the province of residence of the Insured Person without endangering his life or health, even if such service is provided as a result of a sudden Illness or an Accident requiring Emergency treatment;
3. services or treatment are received as a result of routine medical care;
4. a Medical Emergency no longer exists and medical evidence indicates that the Insured Person is able to return to his/her province of residence or territory of residence. **Once a Medical Emergency ends, no further benefits are payable for the continuing treatment, recurrence or complication arising directly or indirectly from the condition which caused the medical Emergency.** If the Insured Person does not agree to repatriate in as recommended by Sigma Assistel, no further benefits will be payable relating to that Medical Emergency;
5. services or treatment were not pre-approved by Sigma Assistel where and when required. If an Insured Person fails to contact Sigma Assistel immediately when he requires Medical Emergency services that require Hospitalization outside the country, the Insurer may reduce or deny Reimbursement of a portion of the incurred Eligible Expenses. It is understood that the Insurer is not responsible for the availability or quality of such services;
6. eye glasses, contact lenses, hearing aids or prescriptions for the same;
7. air travel, other than as a passenger in a commercial aircraft licensed to carry passengers for hire;
8. pregnancy, childbirth or miscarriage, or any complications arising from pregnancy within 8 weeks of the expected delivery date;
9. mental or emotional disorders that do not require hospitalization;
10. abuse of medication, drugs or alcohol, intentional self-injury, suicide or attempt thereat, whether sane or insane. (This exclusion does not apply to Trip Interruption and Delay claims);
11. any Emergency transplants including but not limited to organ transplants and bone marrow transplants;
12. injuries sustained by the individual while operating a motor vehicle, either while under the influence of any intoxicant or if his/her blood contained more than 80 milligrams of alcohol per 100 millilitres of blood at the time of injury;

13. if the Insured Person is not covered under government health and Hospital insurance plans;
14. preventive, experimental or patented medicines or vaccines;
15. regular care for a chronic condition, check-ups or treatment for cosmetic purposes;
16. any treatment or surgery that can reasonably be delayed until the Insured Person returns to Canada for such treatment;
17. voluntary participation in war or act of war; or the commission of a criminal act;
18. voluntary participation in a riot or civil disorder;
19. willful exposure to peril except in an attempt to save human life;
20. expenses covered by any Provincial or Federal Act or Acts;
21. for health care and Hospital expenses incurred for an Insured Person who cannot be repatriated in his province of residence and who refuses medical treatment prescribed by the Physician, and approved by "Sigma Assistel";
22. for any Medical Emergency incurred in a country or region for which the Canadian government issued, prior to the Trip departure date, one of the following travel warnings:
    i) avoid non-essential travel; or
    ii) avoid all travel.

    The Insured Person who is in the country or region for which a travel warning is issued during his Trip is not subject to this exclusion. However, he must make the necessary arrangements to leave the country or region as soon as possible;
23. cardiac procedures, including cardiac catheterization, angioplasty, angiograms, angiographs or surgery, including any associated diagnostic charges, unless approved by Sigma Assistel prior to being performed, except in extreme circumstances where surgery is performed on an Emergency basis immediately following admission to Hospital;
24. expenses incurred where it is determined this coverage was purchased specifically to obtain Hospital and / or medical treatment outside the Insured Person's province of residence whether or not recommended by Your Physician;
25. diagnostic procedures such as surgery, Magnetic Resonance Imaging (MRI) and Computerized Axial Tomography (CAT) scans, sonograms, ultrasounds and biopsies, including any associated charges, unless specifically approved by Sigma Assistel prior to the procedure being performed;
26. any expenses (including diversion charges) related to the operation of a Common Carrier, regardless if the Common Carrier is licensed for the transportation of passengers for compensation or hire;
27. an Emergency which occurs while the coverage is not in force as per the Insured Person's Trip;
28. medical treatment and expenses incurred to refill ongoing medication;
29. medical emergencies which are not sudden and unforeseen; or

30. loss arising as a result of the bankruptcy or insolvency of a travel agent, agency, broker or travel supplier, under Trip Interruption or Trip Cancellation.

IN-PROVINCE EXTENDED HEALTH CARE PLAN DETAILS

GENERAL PROVISIONS

1. MEMBER ELIGIBILITY

A Regular or Associate Member of the **MUNICIPAL PENSION RETIREES' ASSOCIATION (MPRA)** becomes eligible to be insured under this Plan on the date:

a) he/she becomes a Regular or Associate Member of the **MUNICIPAL PENSION RETIREES' ASSOCIATION**; and

b) his/her coverage under an employer-sponsored Group Insurance Plan terminates; or

c) his/her coverage under his/her Spouse's Group Insurance Plan terminates; or

d) his/her coverage under a Group Insurance Plan, other than those plans mentioned in b) and c) above, terminates

Application must be made on, before or within 60 days of the preceding dates, or during an Open Enrolment Period; otherwise the applicant will be deemed a Late Applicant and will be required to provide medical evidence satisfactory to the Insurer and must be approved by the Insurer for coverage.

2. DEPENDENT ELIGIBILITY

The insurance of an eligible Dependent shall become effective on the later of:

a) the date the Member is first eligible;

b) the date the Member first makes written application for this insurance;

c) the date the Dependent's evidence of insurability is approved by the Insurer; or

d) the date the Dependent is no longer confined (excluding newborns).

If a Member has Family Coverage under the policy, the Member is not required to make written application to insure additional Dependents, if no additional premium is required. Evidence of Insurability is required if the Dependent is a Late Applicant. If evidence of Insurability is required and/or the Dependent is confined to a Hospital, the effective date of insurance shall be the first date the Dependent is not confined to a Hospital or the date insurance coverage is approved by the Insurer. In no event, will the Dependent's insurance become effective before the Member's insurance becomes effective.

Confinement in a Hospital shall not postpone the effective date for:

a) A child born while the Member's Dependents are insured; or

b) A mentally or physically handicapped child of any age.

3. EFFECTIVE DATE OF COVERAGE

The insurance of eligible member shall become effective on the later of:

a) If applying during the Eligibility Period, within 60 days of losing coverage under an employer group plan, Spouse's group plan or other group Extended Health Care plan, on the date the prior coverage terminated; or

b) If applying after the Eligibility Period, after 60 days of losing coverage under an employer group plan, Spouse's group plan or other group Extended Health Care plan, on the date the completed application is approved by the Insurer.

4. PARTICIPATION REQUIREMENT

Changes between Drug Options A & B can be requested. An Insured Person must participate in Drug Option B for a minimum of 24 months from the effective date of coverage before switching to Drug Option A.

5. LATE APPLICANT

A Late Applicant, who applies after the Eligibility Period for the Prestige Travel Plan with Extended Health Care, or an Open Enrolment Period, will be required to provide medical evidence satisfactory to the Insurer and must be approved by the Insurer for coverage.

6. EXTENDED COVERAGE FOR DEPENDENTS

a) Coverage for Dependents of a Deceased Member

Coverage for eligible Dependents shall continue following the death of the member, provided premiums continue to be paid, until:

i) the date the policy terminates; or

ii) the Dependent's coverage otherwise would terminate under the other provisions of the policy.

b) Coverage upon Remarriage of a Deceased Member's Surviving Spouse

Upon Remarriage of a Deceased Member's Surviving Spouse, the new Spouse and any Dependent children acquired, resulting from the remarriage will be eligible for coverage, subject to the Eligibility provisions for Dependents.

7. DUAL COVERAGE

Eligible children may be insured as Dependents of only one (1) member even though both parents may be insured as eligible Members. A Spouse cannot be insured as a Dependent if also insured as a Member.

8. PREMIUM PAYMENTS

The premiums applicable to this insurance are payable one (1) month in advance on each premium due date. Premiums are paid by regular, interest-free monthly bank deductions as authorized on the application for benefits.

9. GRACE PERIOD

After the initial premium payment, each subsequent payment must be received within thirty-one (31) days after the premium due date, otherwise Your coverage will be automatically terminated at the end of the grace period.

10. TERMINATION OF A MEMBER'S INSURANCE

Coverage for a Member under this plan shall terminate on the earliest of the following dates:

a) the date the plan is terminated by the Insurer or Policyholder;

b) the end of the month in which the Member requests in writing to terminate coverage;

c) the date the Member no longer makes premium payments, following the 31 day grace period;

d) the date the Member is no longer eligible for coverage;

e) the date the Member enters the Armed Forces of any country, state or international organization on a full-time basis; or

f) the date the Member dies.

11. TERMINATION OF A DEPENDENT'S INSURANCE

Coverage for a Dependent under this plan shall terminate on the earliest of the following dates:

a) the date the plan is terminated by the Insurer or Policyholder;

b) the end of the month in which the Member requests in writing to terminate Dependent coverage;

c) the date of termination of the member's coverage, except that coverage may be continued in the event of the member's death in 6(a) Extended Coverage for Dependents of the general provisions;

d) the date the contributions to the cost of coverage are ceased;

e) the date the Dependent is no longer eligible for coverage;

f) the date coverage for Dependents is terminated as described under "Eligible Dependent" (i.e. attain age 21 or 25 for full-time students); or

g) the date the Dependent enters the Armed Forces of any country, state or international organization on a full-time basis.

12. REINSTATEMENT OF INSURANCE FOR NON-PAYMENT

If insurance is terminated for non-payment of premium, coverage can be resumed providing the outstanding and current premium owing is paid and provided that the insurance had not been terminated for more than three (3) consecutive months. If insurance had been terminated for more than three (3) months due to non-payment of premium, the member will be considered a Late Applicant.

13. INCONTESTABILITY

No statement made by You in Your application for insurance, except for fraudulent statements and omissions, shall be used by the Company to contest a claim after Your insurance has been in force for two (2) years following the policy issue date.

14. APPLICABLE LAW

Any provision of this policy which is in conflict with any federal, provincial or territorial law of the Insured Person's place of residence is amended to comply with the minimum requirements of that law. All other provisions shall remain in full force and effect.

15. NON-WAIVER PROVISIONS

Failure by the Company or the Plan Administrator to enforce any provision of this policy in a given circumstance shall not constitute a waiver of the right to enforce the provision at any other time. No one other than the Company has the authority to change or waive any provision of the policy.

16. LIMITATION OF LIABILITY

The Company or Plan Administrator are not responsible for the availability, quality or results of any medical treatment or transportation, or the failure of an Insured Person to obtain medical treatment.

17. RIGHT OF EXAMINATION OF THE MASTER POLICY

An Insured Person and/or his or her personal representative shall, upon request, be permitted to examine this Master Policy, at the Plan Administrator's place of business or the head office of the Policyholder, for the purpose of ascertaining the benefits, terms and provisions of this agreement; provided that any such examination takes place during the normal business hours.

DESCRIPTION OF BENEFITS – IN-PROVINCE EXTENDED HEALTH CARE

If the Insured Person incurs charges for medically necessary treatment, services or supplies which are covered under the policy, the Company will pay benefits, subject to the terms, conditions and limitations outlined in the policy. Benefits/maximums indicated are on a **per Insured Person basis**, unless otherwise specified.

Benefits are payable to the extent that:

a) the charges are reasonable and customary for the services rendered and do not exceed the maximum amount specified;

b) there is no law or legislation prohibiting insuring such services in the Insured Person's province or territory of residence;

c) the services were authorized in writing as medically necessary by a Practitioner operating within the scope of his or her license except as otherwise stated;

d) the amount claimed is not covered, or exceeds the amount allowed under the Government Health Insurance Plan for the services provided; and

e) the charges are for treatment of an illness or injury.

Under this policy, coverage for medical expenses is supplementary to and not a replacement for coverage under the Insured Person's Government Health Insurance Plan in their province or territory of residence.

Eligible Expenses are reimbursed at 80%, unless otherwise specified. Charges for the following services are included as Eligible Expenses for Reimbursement under Your Policy:

1. DIRECT PAY PRESCRIPTION DRUGS AND MEDICINES

PRIMARY PLAN

(For Members with Extended Health Care coverage under the Municipal Pension Plan [or other government pension plan])

A Member can choose between two (2) Calendar Year maximums:

PLAN 1: If either You or Your Spouse was born in 1939 or earlier, choose from two (2) Calendar Year maximums:

- **DRUG OPTION A:** $1,200 per Household*.
- **DRUG OPTION B:** $2,500 per Household*.

PLAN 2: If both You and Your Spouse were born in 1940 or later, choose from two (2) Calendar Year maximums:

- **DRUG OPTION A:** $1,500 per Household*.
- **DRUG OPTION B:** $3,500 per Household*.

**Annual Household maximum includes $850 of coverage for the Member (reimbursed at 100%)*

ALTERNATE PLAN

(for Members without Extended Health Care coverage under the Municipal Pension Plan [or other government pension plan])

80% Reimbursement of the first $1,500 of Your Household's out-of-pocket expenses, then 100% Reimbursement, to Your choice of two (2) Calendar Year maximums:

PLAN 1: If either You or Your Spouse was born in 1939 or earlier, choose from two (2) Calendar Year maximums:

- **DRUG OPTION A:** $1,200 per Household.
- **DRUG OPTION B:** $2,500 per Household.

PLAN 2: If both You and Your Spouse were born in 1940 or later, choose from two (2) Calendar Year maximums:

- **DRUG OPTION A:** $1,500 per Household.
- **DRUG OPTION B:** $3,500 per Household.

Both plan options cover drugs, sera and injectables, and compounds/mixtures **included in the British Columba Provincial Formulary (i.e. PharmaCare or equivalent)**, which by law require a prescription from a Physician, Dentist or practitioner legally qualified to prescribe, and dispensed by a licensed pharmacist. In addition, the plan covers both non-prescription drugs (which have a Drug Identification Number) and supplies required for treatment of cystic fibrosis, diabetes (e.g. lancets, test strips, syringes), heart disease or Parkinson's.

Please Note: Maximum allowable supply is 100 days. If You plan to take an extended vacation, You can obtain up to a total 200 day supply by completing a Vacation Supply form. To obtain this form, You or Your pharmacist may contact Johnson Plan Benefits Claims. The total cost of the prescription will count towards the Calendar Year maximum in the year in which the drugs are purchased.

Limitations in coverage, include that prescriptions be subject to:

a) a maximum dispensing fee of $10 per script;

b) a maximum markup to the manufacturer's list price of 8%;

c) PharmaCare (or equivalent) low cost alternative (LCA) and reference drug program (RDP) pricing; and,

d) Coverage in effect under the provincial drug plan as first payor.

IMPORTANT: For Primary Plan Members the following non-drug benefits are Eligible Expenses for Your Spouse and Dependent Children only (i.e. Member covered for prescription drugs and Prestige Travel Plan only). For Alternate Plan members the following non-drug benefits are Eligible Expenses for You, Your Spouse and Dependent Children.

2. ACCIDENTAL DENTAL

Services by a Dentist or Dental Surgeon to repair or replace damaged natural teeth, (crowned or capped teeth are considered to be natural teeth) to set or repair a broken or dislocated jaw when the injuries are caused by an external accidental blow to the head or mouth (and not caused by any object or food intentionally placed in the mouth) subject to a maximum of $1,000 per Calendar Year. The injury must have occurred after the effective date of coverage under the plan and while coverage is in force.

Treatment must be completed within six (6) months following the date of the injury. No benefit will be payable for charges incurred for such services after the termination date of this policy or after the termination date of the Insured Person's coverage. Chewing Accidents are not covered.

Payment for insured services will be based on the Dental Fee Guide which reflects current and customary fees for General Practitioners in effect on the date and location where the charges were incurred. The British Columbia Fee Guide will apply for use outside of Canada.

The claim must be accompanied by one of the following: (i) an official police or accident report, (ii) an accidental dental claim form filled out by a licensed Dentist, Dental Surgeon, and injured Insured Person (form to be provided by the Plan Administrator), or (iii) an Emergency Hospital or medical facility report.

3. AMBULANCE SERVICES

a) licensed ground ambulance to and from a local Hospital **when medically necessary for Emergency treatment**;

b) Emergency transportation inside the person's province of residence by a licensed ambulance, air-ambulance or by any other public transportation vehicle for Emergency transport, to the nearest Hospital in which the required treatment can be provided, subject to one (1) return Trip per person per Calendar Year; and,

c) non-Emergency transportation inside the person's province of residence by a licensed ground ambulance, on the prior recommendation of the attending Physician, if the patient is non-ambulatory and cannot be transported by any other means other than ambulance, subject to one (1) return trip per person per Calendar Year. Charges for non-Emergency use of an ambulance used solely as a means of transportation in lieu of other forms of transportation, i.e. taxi, bus, para-transport, are not covered.

4. DIAGNOSTIC SERVICES

Reimbursement of the eligible portion, where applicable, that has not been paid by Your Provincial Government Health Insurance Plan for:

a) Diagnostic procedures and radiology (when not confined to a Hospital). Charges for services and details of procedures must be written on a lab invoice, which indicates that the test is not covered by provincial health insurance; and

b) Oxygen and its administration in both province of residence and outside province of residence.

Expenses related to maintenance of equipment are not eligible for Reimbursement.

5. HEARINGS AIDS

Charges for the purchase or repair of either a single or dual contact hearing aid(s), upon the written recommendation of the attending licensed, certified or registered audiologist, otolaryngologist, otologist or Physician. The maximum benefit payable is $1,000 per five (5) Consecutive Calendar Years.

Expenses related to batteries are not eligible for Reimbursement.

6. HOME CARE

After a Hospital stay of at least 24 hours, home care expenses are covered up to a maximum of $50 per day, for up to 10 days, upon written recommendation of a Physician and provided in Your own home. This service may be rendered by persons without professional skills or training working under the supervision of a Home Care Agency or a Home Health Care Agency. The level of care includes assisting with:

a) activities of daily living (eating, bathing, dressing);

b) ambulation and exercise;

c) self-administered medications;

d) homemaker services or home health aide services;

e) services needed to maintain or improve the insured's functional ability;

f) respite care to maintain Your health or safety and to provide temporary relief from care giving duties to a member of Your immediate family or other unpaid person who is Your primary caregiver; and,

g) outpatient services and supplies not covered by the provincial government.

The home caretaker must not ordinarily reside in Your home or any of Your Dependents and must not be related to You by blood or marriage.

7. HOSPITAL ACCOMMODATION

100% Reimbursement of the difference between standard ward and semi-private or private Hospital charges in a licensed Hospital in Canada, including a convalescent or rehabilitative Hospital (not homes), limited to a maximum of $100 per day (excluding charges for accommodation and care in a chronic care facility).

8. MEDICAL AIDS AND APPLIANCES

Coverage for the purchase or rental of items listed below are subject to charges which are reasonable and customary for the area where incurred (as determined by the Plan Administrator's records) and subject to internal limits. Claims for the following eligible aids and appliances must include written authorization from the attending Practitioner and must be for therapeutic use only:

a) trusses, splints, braces, crutches, canes, walkers, casts;

b) ostomy and ileostomy supplies;

c) purchase of artificial limbs or eyes, or breast prosthesis including two (2) mastectomy bras per Calendar Year;

d) purchase of one (1) wig to a limit of $400 per Calendar Year;

e) surgical support stockings, subject to a maximum benefit of $200 per Calendar Year;

f) custom-made orthopaedic shoes, which are not part of a brace, and orthotics, including orthopaedic adjustments to stock items and excluding the cost of pre-manufactured footwear, subject to a maximum benefit of $500 per three (3) Calendar Years for orthopaedic shoes and $300 per three (3) Calendar Years for orthotics;

g) orthopaedic shoes that are attached to and form part of a brace;

h) incontinence supplies; subject to a maximum benefit of $200 per Calendar Year;

i) a medically necessary geriatric or lift chair, subject to a combined lifetime maximum of $1,000; and,

j) visual enhancement equipment, subject to a maximum of $200 per two (2) Calendar Years.

The following prescribed medical devices and equipment will be covered under the vision enhancement benefit:

a) An optical scanner or similar device, as recommended by a Physician, designed to enable an individual with a severe vision impairment to read print;

b) A device or equipment, including a synthetic speech system, Braille printer and large print-on-screen device, as recommended by a Physician, designed exclusively for use by an individual who has a severe vision impairment; and

c) Hand-held magnifiers.

Reimbursement of charges, upon written recommendation of a Physician and completion of an authorization form provided by the Program Administrator, for the purchase or rental of:

a) A manual wheelchair to a maximum of $2,000 per five (5) Calendar Years, or an electric wheelchair to a maximum of $5,000 per five (5) Calendar Years, or a hospital bed (or purchase if approved by the Insurer);

   Please Note: To be considered for a hospital bed, the patient must be bedridden and non-ambulatory;

b) A Continuous Positive Air Pressure unit (CPAP) including eligible supplies (e.g., mask, headgear, tubing, filter and humidifier) to a maximum of $2,000 per five (5) Calendar Years. **Please Note:** A copy of the sleep study is required; and,

c) Respirator ventilator.

9. PARAMEDICAL SERVICES

Reimbursement of charges for the services, including laser therapy, of any of the paramedical practitioners listed below when the practitioner is:

a) Licensed, certified or registered; and

b) Providing services within his/her recognized field.

When applicable, benefits are only payable in excess of the yearly maximum benefit payable under the insured individual's provincial plan. A statement of diagnosis from Your Physician may be required.

A combined maximum of $1,000 per Calendar Year applies to benefits payable under this plan for the following paramedical practitioners:

- Acupuncturist;
- Athletic Therapist;
- Chiropractor;
- Dietician / Nutritionist;
- Massage Therapist (Physician recommendation required);
- Naturopath;
- Osteopath;
- Physiotherapist;
- Podiatrist / Chiropodist;
- Psychologist; and,
- Speech Therapist.

10. PRESCRIBED HEALTH EDUCATIONAL PROGRAMS

Reimbursement of charges for wellness, rehabilitation and other medically related educational program(s) are subject to a maximum of $100 per Calendar Year. A Physician's note including diagnosis and recommendation of the program is required. This does not include fitness club fees and/or memberships.

11. PRIVATE DUTY NURSING

Reimbursement of charges to an overall maximum benefit of $3,000 per three (3) Consecutive Calendar Years for the professional services of a Registered Nurse (R.N.), a Licensed Practical Nurse, or a Registered Nursing Assistant upon written recommendation of a Physician and completion of an authorization form provided by the Program Administrator, while the patient is not confined to a Hospital or nursing home subject to the provision that such nurse does not ordinarily reside in the home of the member or any of the member's Dependents and is not related to the member by blood or marriage.

Custodial (i.e. housekeeping), homemaking and companion services are not covered.

12. REFERRAL FOR TREATMENT OUTSIDE CANADA

When the Insured Person is referred by a Physician in Canada to a Hospital outside Canada for medically necessary treatment which is unavailable in Canada and for which there is no medically sufficient alternate treatment available in Canada, and which is eligible for Reimbursement in whole or in part by a provincial medical plan, the following expenses in excess of any provincial government plan allowance are covered for Reimbursement:

a) reasonable and customary Hospital charges for ward accommodation, subject to a maximum payment for 31 days during any one period of disability; and
b) reasonable and customary charges for the services of a Physician.

13. VISION CARE

Reimbursement of charges for the following vision care services and supplies when recommended by an ophthalmologist or optometrist:

a) prescription lenses, frames and fitting of prescription eyeglasses, including prescription sunglasses and contact lenses not covered in b) below, up to a maximum benefit of $300 per two (2) Consecutive Calendar Years. If new lenses are required due to eye surgery, additional benefits in excess of those described above will be payable up to a lifetime maximum of $175.
b) contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus (conical cornea), or aphakia, provided visual acuity can be improved to at least the 20/40 level by contact lenses but cannot be improved to that level by eyeglasses, subject to a maximum benefit of $200 per two (2) Consecutive Calendar Years;
c) visual training or remedial exercise not covered by the provincial health plan; and
d) ocular examinations, including refraction, limited to $100 per two (2) Consecutive Calendar Years.

CLAIMS

1. ELECTRONIC SUBMISSION OF EXTENDED HEALTH CARE CLAIMS

The Johnson Health and Dental card may be presented to your pharmacist who will bill Johnson Inc. directly for your eligible prescription drug expenses. At the time of filling a prescription, you will be responsible only for the payment of the coinsurance, and any drugs that are not eligible for reimbursement under the MPRA Extended Health Care plan. In the unlikely event that your pharmacist may ask you to pay for your drugs, please do so and then mail your receipts for reimbursement to Johnson Inc. using a claim form. The back of your health and dental identification card includes contact information for pharmacy use should your pharmacist have any questions or concerns regarding electronic submission of prescription drugs.

Johnson Inc. has entered into an arrangement with TELUS Health Solutions to offer eClaims, a secure, web-based way for extended healthcare providers to submit claims electronically for their patients. At this time, eClaims submission is available for the following extended healthcare services nationally: chiropractors, physiotherapists, opticians and optometrists, massage therapists, acupuncturists, and naturopathy providers. Please note that your paramedical provider needs to be signed up with TELUS Health Solutions in order for the eClaims service to be available.

2. NOTICE AND PROOF OF CLAIM FOR EXTENDED HEALTH CARE

When the Plan Administrator receives a written completed claim form and original receipts, payment will be made to the Insured Person, for charges for Eligible Expenses, upon submission of written proof of claim, satisfactory to the Plan Administrator, and subject to the terms and conditions of the Master Policy.

An Insured Person must submit a pre-authorization form completed by the attending Physician for any treatments, services or supplies which require the prior approval of the Plan Administrator, before a claim shall be paid.

Charges for Eligible Expenses submitted as a claim shall be considered to have been incurred on the date the person received the treatment, services or supplies, or incurred an obligation with the provider for such treatment, services or supplies.

Written proof of claim, satisfactory to the Company, must be submitted to the Plan Administrator, by the end of the Calendar Year following the year in which the claim was incurred.

On termination of an Insured Person's coverage for any reason, including as a result of termination of this policy, written proof of claim satisfactory to the Plan Administrator must be received no later than 90 days following the date of termination.

Failure to give notice of claim or furnish proof of claim within the time prescribed herein does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date a claim arises hereunder, if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

For claims information, contact the Johnson Inc. claims department at 780-413-6599 or 1-877-413-6599.

3. CO-ORDINATION OF BENEFITS BETWEEN TWO PLANS

If you are covered under more than one group plan simultaneously, payment for benefits provided under the policy will be co-ordinated so that the total does not exceed 100% of the Eligible Expenses incurred in compliance with the CLHIA guidelines. This plan is second payor to all government health insurance.

A copy of the explanation of benefits from the other insurance carrier, photocopies of all receipts and a completed claim form, are required for consideration of the claim balance.

Note: This provision does not apply to any government health insurance.

ORDER OF BENEFIT DETERMINATION

If a person is eligible to receive a benefit under the policy and the same or a similar benefit under any other contract, policy or plan, payment of benefits shall be decided in the following manner:

a) a plan without a Co-ordination of Benefits provision pays before a plan with a Co-ordination of Benefits provision;

b) when both plans contain a Co-ordination of Benefits provision, priority of benefit payment is attributed to the plan under which the Insured Person is entitled to receive payments in the following order:

   i) first to the plan to which the Insured Person is the insured participant or member; or

   ii) second to the plan that the Insured Person is a dependent of the insured participant or member; or

   iii) a person who is an insured Dependent child under more than one plan, should submit to the plan where the parent, whose birthday is the earlier date in Calendar Year, is the insured participant or member; or

   iv) if priority cannot be established in the above manner, the benefit payments shall be pro-rated between or amongst the plans in proportion to the amounts that would have been paid under each plan had there been coverage by just that plan.

The Company is entitled to make payments to, and to recover payments from, other plans, as necessary in accordance with the intentions of this provision.

The Plan Administrator may (subject to the consent of the Insured Person, if so required by law), obtain from or release to any person or corporation, any information considered necessary to implement this provision and facilitate the payment of benefits under this agreement.

4. RIGHT TO RECOVER PAYMENTS

If after benefit payments have been made to or on behalf of any Insured Person, it is discovered that, due to clerical, electronic or administrative error, payment was made inadvertently or in excess of the amount(s) required to satisfy the terms of this policy, the Company reserves the right to recover the

inadvertent or excess payment(s) from the Insured Person or to the organization to whom the payment was paid.

If the amount of the inadvertent or excess payment(s) cannot be recovered within a reasonable time period, the Company has the right to reduce future benefit payments to or on behalf of the Insured Person until such amount(s) are recovered in full.

5. SUBROGATION FROM A THIRD PARTY

If the Company pays any benefits in respect of a sickness or injury where a third party is liable, the Insured Person's right of recovery shall be subrogated to the Company to the extent of the benefits paid, and the Company may bring action in the name of the Insured Person to enforce such right where permitted by law.

In such an event, the Insured Person and his/her legal representative shall co-operate with the Company to facilitate recovery and settlement of any payments, in order to satisfy the intent of this provision.

6. AUTHORIZATION

An Insured Person as a condition precedent to receiving benefits under this agreement, consents to, authorizes and directs any person or corporation to provide the Plan Administrator with any reports, records, x-rays or other information relating to the treatment, services or supplies for which the claim is made.

7. LIMITATION OF ACTION

In the event of a claims dispute, an Insured Person must bring any legal action or proceeding against the Company within 24 months of the date the charges were incurred or the date on which they return to their province or territory of residence, whichever applies. All legal actions or proceedings must be brought in the Canadian province or territory in which the Insured Person permanently resides.

8. DUPLICATE COVERAGE

If there is any duplication of expenses between both In-Province Extended Health Care and Prestige Travel Plan Eligible Expenses, expenses which are incurred outside the insured individual's province or residence in the event of an Emergency while travelling shall be payable as Prestige Travel Plan Eligible Expenses, not as In-Province Extended Health Care Eligible Expenses.

EXCLUSIONS AND LIMITATIONS

BENEFITS ARE NOT PAYABLE FOR IN-PROVINCE EXTENDED HEALTH CARE RESULTING FROM:

1. services which are insured by the Insured Person's provincial government health plan or expenses which the Insurer is not permitted, by any law or regulation, to cover; or government actions implemented during the policy year which may impact the Plan;
2. general health examinations and examinations required for use of a third party;
3. eye examinations, except where included as an eligible expense;
4. a surgical procedure or treatment performed primarily for cosmetic reasons, or charges for Hospital confinement for such surgical procedure or treatment unless such surgery or treatment is for accidental injuries and begins within 90 days of the accident;
5. medical treatment or surgical procedures by a Physician other than described under Physicians' Services in the Benefits Section;
6. expenses incurred by a Physician, Dentist or denturist expenses for travel time, broken appointments, transportation costs, completion of insurance forms, room rental charges or consultation received by any telecommunication means, other than as specifically provided under Eligible Expenses;
7. services or supplies which are furnished without the recommendation, unless specified otherwise, and approval of a Physician acting within the scope of his/her license;
8. services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy;
9. services or treatment for occupational injuries or diseases covered by any Workers' Compensation law or similar legislation;
10. expenses which would not normally have been incurred but for the presence of this insurance or for which the member or Dependent is not legally obligated to pay;
11. dental work where a third party is responsible for payment of such charges;
12. services or supplies which were necessitated either wholly or partly, directly or indirectly, as the result of committing, attempting, or provoking an assault or criminal offence;
13. services or supplies which were necessitated either wholly or partly, directly or indirectly, as the result of a war or act of war (whether declared or undeclared), service in the armed forces of any country, insurrection or riot, or hostilities of any kind;
14. services or supplies for treatment of injuries that are intentionally self-inflicted;
15. drugs, sera, injectable drugs or supplies that are not approved by Health & Welfare Canada (Food & Drug), are in excess of Extended Health Care Drug Plan limitations, or are experimental or limited in use whether or not so approved;

16. drugs described as “lifestyle” drugs which include but are not limited to treatment for smoking cessation, weight loss, hair growth, sexual dysfunction, vaccines, vitamins, fertility treatment or for cosmetic purposes;
17. experimental medical procedures or treatment methods not approved by the Canadian Medical Association or the appropriate medical specialty society;
18. charges for drugs that can be purchased without a Physician’s or a Dentist’s prescription, whether or not a Physician or Dentist has prescribed them;
19. accommodation in a rest home, nursing home, convalescent home, health spa, a place for custodial care, a home for the aged, or a chronic care facility;
20. nursing home services provided in a nursing home;
21. Out-of-Province/Country Emergency Travel Eligible Expenses; and,
22. unspecified items in the foregoing lists of Eligible Expenses.

CONTACT INFORMATION

THE PLAN WAS DEVELOPED BY THE MUNICIPAL PENSION RETIREES' ASSOCIATION AND JOHNSON INC. IT IS ADMINISTERED BY JOHNSON INC. AND IS UNDERWRITTEN BY DESJARDINS FINANCIAL SECURITY.

JOHNSON INC.

8:30 a.m. to 4:30 p.m., Monday through Friday
Website: www.johnson.ca/mpra

BENEFIT SERVICES DEPARTMENT

110 – 9440 202 Street
Langley, BC V1M 4A6
Telephone: (604) 881-8840
Toll Free in North America: 1-866-799-0000
Fax: (604) 881-8828
pbservicewest@johnson.ca

BENEFIT CLAIMS DEPARTMENT

11120 – 178th Street
Edmonton, AB T5S 1P2
Telephone: (780) 413-6599
Toll Free in North America: 1-877-413-6599
Fax: (780) 420-6082
pbclaimswest@johnson.ca

IN THE EVENT OF A TRAVEL MEDICAL EMERGENCY, PLEASE CONTACT SIGMA ASSISTEL IMMEDIATELY:

SIGMA ASSISTEL

24 hours a day, seven days a week

EMERGENCY TRAVEL DEPARTMENT

Toll Free in North America: 1-877-775-3695
Other Countries (Call Collect): (514) 875-3695
Fax: (514) 875-7729

EMERGENCY TRAVEL CLAIMS ADDRESS

Attention: Claims Department
C.P. 3950
Levis, QC G6V 8C6

PRIVACY STATEMENT

The Federal and Provincial Governments enacted legislation to protect the personal information of Canadians. This statement informs You of the steps taken to comply with the legislation. Desjardins Financial Security and Johnson Inc., may use Your personal information for the following purpose: They may collect personal and other information about You to provide Your requested coverage and services or to process claims. The primary sources of information are You, MPRA and Your medical advisors. To administer or otherwise provide You the coverage and services requested, Desjardins Financial Security may collect information from individuals, groups or companies from whom collection is necessary.