Leisure Travel Benefit

Purpose of Coverage

The Insurer will pay the eligible expenses described in this benefit, subject to the conditions outlined below, for a maximum coverage duration period of 4 consecutive weeks. Benefits are paid on a 100% basis without a deductible and up to an overall maximum reimbursement of $1,000,000 per Insured, per lifetime.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *General Conditions* provision of this policy.

Emergency: an illness or injury that requires immediate medical treatment due or related to:

- an injury resulting from an accident;
- a new medical condition which begins during a trip;
- a medical condition that existed prior to a trip provided that it is stable.

Stable means the Insured, in the 90 days before the departure date, has not:

- been treated or evaluated for new symptoms or related conditions;
- had symptoms that increased in frequency or severity, or examination findings indicating the condition has worsened;
- been prescribed a new treatment or change in treatment for the condition (generally does not include reductions in medication due to improvement in the condition, or regular changes in medication as part of an established treatment plan);
- been admitted to or treated in a hospital for the condition; or
- been awaiting new treatments or tests regarding the medical condition (does not include routine tests).

The above criteria will be considered collectively in relation to the overall medical condition.

Hospital: A facility that:

- is licensed as an accredited hospital outside of the Insured's province of residence;
- offers care and treatment to either inpatients or outpatients;
- has a registered nurse on duty 24 hours a day;
- has a laboratory; and
- has an operating room where surgical operations are performed by a legally qualified surgeon.

Coverage excludes any facility used primarily as a clinic, continued or extended care facility, convalescent home, rest home, health spa or drug addiction or alcohol treatment centre unless specifically authorized by the Insurer.

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Immediate Family Member: An Insured's parents, spouse, child, brother or sister.

Incident: An individual occurrence of emergency illness or injury.

Travel Companion: Persons who are sharing prepaid travel arrangements with the Insured. No more than 3 persons can qualify as a travel companion for any given Trip.

Trip: Travel outside the Insured's province of residence for leisure purposes only. For International students participating in a study away program out of province in Canada, this includes occasional absence from one's residence in the province of the «study away program» for the purpose of a vacation or leisure.

For International students participating in a study away program (outside Canada), this includes occasional absence from one's residence in the country of the «study away program» for the purpose of a vacation or leisure.

Trips to and from the Insured's country of origin and vacations in the Insured's country of origin are excluded.

What the Insurer Will Pay

The Insurer will pay for the expenses explicitly listed in the categories below, subject to the following terms and conditions:

- prior approval of the Insurer must be obtained before the eligible expense is incurred;
- the charges must be usual, customary and reasonable, meaning that:
  - the amount charged is consistent with the amount generally charged by health practitioners for similar products or services in the geographical area in which the service or supply is being purchased; and
  - the frequency and quantity in which services or supplies are purchased by the Insured are, in the opinion of the Insurer in consultation with its health care consultants, consistent with the frequency and quantity that would usually be prescribed or needed for the Insured's condition;
- payment is limited in accordance with the *Exclusions and Limitations* provision of this benefit;
- payment of this benefit is limited to amounts that are in excess of coverage provided by any other plan (where a court determines that this policy and any other plans provide primary coverage, this benefit will be co-ordinated with the other plan); and
- payment is subject to post-payment audit in accordance with the following provision:The Insurer has the right, at any time, to inspect or audit the health and claim records of the Insured in relation to a claim for benefits. This right to inspect or audit applies to records held by the Insurer or in the files of approved providers and may be exercised by the Insurer or by a third party on behalf of the Insurer.

Emergency Hospital and Medical Travel Coverage

The Insurer will pay the eligible expenses listed in this section if:

- they are incurred as a result of an emergency; and
- the Insurer is satisfied the expense is necessary to stabilize the Insured's medical condition.

Hospitalization: Charges for hospital room accommodation (not a suite of rooms) and for medically necessary inpatient and outpatient services.

Physician Fees: Fees charged for physician or surgeon services.

Medical Appliances: The cost of casts, crutches, canes, slings, splints, trusses, braces or the temporary rental of a wheelchair or scooter, when prescribed by the attending physician.

Nursing Care: Fees for private duty nursing performed by a professional nurse or nursing assistant when prescribed by the attending physician. The nurse providing the service must not be a family member of the Insured or an employee of the hospital.

This coverage excludes nursing fees for custodial care.

Diagnostic Services: Charges for laboratory tests, X-rays and diagnostic imaging, when prescribed by the attending physician.

Drugs: The cost of drugs prescribed by a physician, but only in a quantity sufficient to treat the condition for the duration of trip. The Insured must provide satisfactory proof of purchase of this medication that includes:

- the name of the Insured;
- the date of purchase;
- the name of the medication;
- the Drug Identification Number, if available;
- the quantity and strength of the drug; and
- the total cost.

Paramedical Services: The cost of services rendered by chiropractors, osteopaths, chiropodists/podiatrists and physiotherapists. This coverage excludes charges for X-rays.

Accidental Dental and Other Dental Emergencies: Fees of a dental practitioner for treatment:

a) of damage to natural teeth that occurs as a result of a direct accidental blow to the mouth;

b) that is necessary to repair a fracture or reposition a dislocation of the jaw resulting from an accident; or

c) that is needed to relieve pain caused by an emergency other than those listed in (a) or (b).

With respect to treatment under categories (a) or (b):

- Treatment must begin while the Insured is covered by this benefit and end within 6 months of the accident, unless deferred treatment is approved by the Insurer due to the age of the Insured; and
- the maximum reimbursement per Insured per Incident is $2,000.

With respect to treatment under category (c), the maximum reimbursement per Insured per incident is $200.

Ambulance Service: The cost of ground or air ambulance for transportation of a stretcher patient to the nearest qualified medical facility. This includes the cost of an inter-hospital transfer if the attending physician and The Insurer determine that existing facilities are inadequate for treatment or stabilization.

Repatriation to the Province of Residence or to the country of origin: The cost of repatriating the Insured to their province of residence or to their country of origin to receive immediate medical attention, along with the cost of simultaneously returning a travel Companion or any Immediate Family Member covered by the policy. If Medically Necessary, this cost may include an accompanying medical attendant.

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If returning on a commercial aircraft, coverage includes:

- economy fare to the Insured's home city in Canada; and
- in the case of a medical attendant, round-trip economy fare.

Unless the repatriation or transfer of the Insured is not possible for medical reasons acceptable by The Insurer, The Insurer may require repatriation of any Insured or transfer to other medical facilities. If the Insured refuses repatriation or transfer, all rights to benefits in relation to the incident are terminated.

Transportation to Visit the Insured: The cost of round-trip economy fare (by airline, bus or train) for an Immediate family member to the hospital where the Insured has been confined for 7 or more days if the attending physician provides written acknowledgement that this attendance is required. The Insurer may waive the 7-day waiting period if the Insurer is satisfied that this waiver is required.

The cost of round-trip economy fare (by airline, bus or train) for an immediate family member to identify the body of the Insured, if deceased.

Vehicle Return: The fees charged by a commercial agency to return the Insured's vehicle, whether private or rental, to the Insured's residence or to the nearest appropriate vehicle-rental agency, when the Insured is unable to drive as a result of an emergency illness or injury. A medical certificate from the attending physician confirming the Insured's medical incapacity to operate the vehicle is required. This benefit is subject to a maximum of $1,000 per Trip.

Return of the Deceased: The cost of preparing and transporting the remains of the deceased Insured to their province of residence or to their country of origin, to a maximum of $10,000.

Meals and Accommodation: The cost of commercial accommodation and meals when the Insured's travel is delayed due to emergency illness or injury of the Insured or travel companion. The medical reason for the delay must be verified by the attending physician. The maximum reimbursement is $150 per Insured per day for a maximum of 20 days (up to a total maximum of $3,000 per incident).

All costs must be supported by receipts from commercial organizations.

Worldwide Travel Assistance

The Insurer, through its travel assistance provider, will provide an emergency toll-free line available 24 hours a day, 7 days a week, for Insureds who need medical assistance or general assistance while travelling.

Medical Assistance

If the Insured requires hospitalization or a consultation with a physician as a result of an emergency, the travel assistance provider appointed by the Insurer will provide the following support services:

- direct the Insured to an appropriate clinic or Hospital;
- confirm with the service provider that the Insured is covered;
- ensure a follow-up of the medical file and communicate with the Insured's family physician;
- co-ordinate the return home of a child if the Insured is hospitalized;
- repatriation of the Insured to their province of residence or to their country of origin if the Insured meets the eligibility requirements of this expense;
- arrange for the transportation of an immediate family member to the Insured's bedside if the Insured meets the eligibility requirements of this expense; and
- co-ordinate the return of the Insured's vehicle if the Insured meets the eligibility requirements of this expense.

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General Assistance

In emergency situations, the travel assistance provider appointed by the Insurer will also provide the Insured with the following services:

- transmittal of urgent messages;
- co-ordination of claims;
- services of an interpreter for emergency calls;
- referral to legal counsel in the event of a serious accident;
- settlement of formalities in the event of death;
- assistance with the loss or theft of identity papers; and
- information regarding embassies and consulates.

In addition, pre-travel advice regarding visas and vaccines is available.

The Insurer and its travel assistance provider are not responsible for the quality of medical and hospital care provided to the Insured or for the availability of such care.

Payment of Claims

How Payments are Made

The Insurer may approve payment directly to the service provider. In certain circumstances, the Insured will pay the full cost of any eligible expense at the time of purchase. The Insurer will then reimburse any eligible expenses on receipt of proof of payment from the Insured.

Time Limit to Submit a Claim

Emergency Hospital and Medical Travel Coverage:

The Insurer must receive proof of claim within 4 months of the date the expense was incurred to be eligible for maximum reimbursement under the benefit.

The Insurer will accept claims up to 12 months from the date the expense was incurred. However, in such circumstances, the claim may be subject to reductions for any amounts The Insurer would have been able to co-ordinate with the Participant's government health care coverage had the claim been submitted within the 4-month limitation period.

Exclusions and Limitations

Exclusions Applicable to all Travel Benefit Claims

No payment will be made if:

a) the Insured fails to communicate with the Insurer in the event of medical consultation or hospitalization following an injury or Illness;

b) expenses are incurred beyond the coverage duration period of 4 consecutive weeks;

c) the purpose of the trip is primarily or incidentally to seek medical advice or treatment, even if this trip is on the recommendation of a physician;

d) expenses have already been paid by or are eligible for refund from a third party;

e) expenses are incurred while travelling in the Insured's country of origin;

f) expenses are incurred while travelling in a country (or a specific region of a country) for which there is a Government of Canada travel warning to avoid all travel or avoid non-essential travel, when such travel warning was issued before the departure date and the loss or expense is related to the reason for which the travel warning was issued; or

g) expenses are incurred as a result of:

   i. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;

   ii. an illness or injury that occurred while operating a vehicle under the influence of any intoxicant or with a blood alcohol level that was proven to be in excess of the legal limit in the jurisdiction in which the accident occurred;

   iii. an injury or Illness resulting from non-compliance with medical treatment or therapy that has been prescribed;

   iv. suicide, attempted suicide or voluntary injury or illness; or

   v. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

Specific Exclusions and Limitations

Emergency Hospital and Medical Travel Coverage

No payment will be made for:

a) expenses for any care, treatment, surgery, products or services that:
   i. are not incurred as a result of an emergency;
   ii. are not medically necessary;
   iii. are performed for cosmetic purposes only;
   iv. are not required for the immediate relief of acute pain and suffering; or
   v. could be delayed until the Insured's return to Canada;

b) expenses incurred due to pregnancy or pregnancy complications that occur within 8 weeks of the expected date of delivery; or

c) expenses incurred due to an emergency that occurs while participating in:
   i. a sport for remuneration;
   ii. a motor vehicle or speed contest of any kind; or
   iii. any extreme Sport, defined as an activity with a high level of inherent danger and which often involves speed, height, a high level of physical exertion, highly specialized gear or spectacular stunts.

Pre-existing condition: An illness:

- that begins within 12 months of the date the Insured obtained coverage under this benefit; and
- for which, in the 12 month before the date the Insured obtained coverage under this benefit, the Insured has:
  - had a medical consultation;
  - been prescribed or taken medication; or
  - received treatment, including diagnostic services.

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When Coverage Ends

Coverage ends on the date specified under the *General Conditions* provision of this policy.