Insured: Ms. ABC
Contract No.: XXXXX
Certificate No. : XXX XXX XXX

Home Care Assistance

Home Care Assistance
Insurance Policy

SAMPLE

10-day examination period

In the 10-day period following receipt of the present contract, you may return it to the company or to the agent from whom it was purchased. Full premium will be refunded and the contract will be void from the date of issue

Signed at the company's head office, in Drummondville, Quebec, Canada

Eric Timmons, Secretary

Christian Mercier, Chief Executive Officer

UV Insurance will pay the benefits in accordance with the provisions of this policy. UV Insurance is a business name and trademark of The Union Life Mutual Assurance Company.

UV INSURANCE

Home Care Assistance

Policy specifications

Name and address of the owner
Ms. ABC
3 TURGEON ST.
STE-THERESE, QC, J7E 3H2

Policy number : XXXXX
File number : XXX XXX XXX

Renewal date : January 15th of each year

Insured

	Name	Age at date of issue
Insured	Ms. ABC	67

Product **Home Care Assistance**

Date of issue 15-01-2021

SUMMARY OF BENEFITS AND PREMIUMS

Description	Issue date	Monthly premium
Home Care Assistance PLAN 2	15-01-2021	$105.14

Total monthly premium:	$105.14
Total annual premium :	$1,261.68

SAMPLE

HOMECARE ASSISTANCE
PLAN 1
Benefits schedule

Protection	Coinsurance	Annual Maximum
Part I	**Payable when the insured person is functionally dependent**	
Specialists		
Audiologist	90%	$1,250 per calendar year
Dietitian	90%	$1,250 per calendar year
Naturopath or osteopath	90%	$1,250 per calendar year
Occupational therapist	90%	$1,250 per calendar year
Physiotherapist	90%	$1,250 per calendar year
Podiadrist or chiropodist	90%	$1,250 per calendar year
Respiratory therapist	90%	$1,250 per calendar year
Speech therapist	90%	$1,250 per calendar year
Other expenses Covered at 100 %		
Monitoring system	100%	$1,000 per calendar year
Moving allowance	100%	$1,000 lifetime maximum
Home conversion	100%	$10,000 lifetime maximum
Meals	100%	$500 per month
Purchase or rental of equipment	100%	Unlimited
Respite	100%	$3,000 per calendar year
Transportation expenses	100%	$750 per year
Informal caregiver support	100%	$1,250 per year
Private nurse or personnal support worker	100%	$75 per day, maximum of 200 days per calendar year

SAMPLE

Other expenses

Covered at 90 %

Orthopaedic shoes	90%	Unlimited
External breast prostheses following a mastectomy	90%	$300 per 24 months
Supplies for colostomy, an ileostomy, or a urostomy.	90%	Unlimited
Tens	90%	$500 per 36 months
Purchase of reagent strips, syringes, and needles. Accessories for diabetics, dextrometer or a glucometer.	90%	Unlimited
Hearing aids	90%	$500 per 36 months
Wigs (required for pathological conditions or following chemotherapy treatments)	90%	$300 lifetime maximum
Stockings for varicose veins and phlebitis	90%	2 pairs per calendar year
Maxi-mist machine, including the masks, or a CPAP machine	90%	$500 lifetime maximum
Rental, purchase or repair of non-motorized wheelchair, hospital bed (excluding mattress), ventilator and crutches	90%	$5,000 lifetime maximum
Medical supplies	90%	$1,500 per year
Incontinence supplies-bowel and /or bladder	90%	$1,500 per year

Part II — Payable in case of accident or sickness

Hospitalization and ambulance

Hospitalization	100%	Semi private room, $150 per day 180 days lifetime maximum. If no semi-private room available, $50 per day of hospitalization, from the second day of hospitalization
Convalescent hospital	100%	Semi private room $50 per day, Maximum of 120 days
Ambulance	100%	Unlimited
Air ambulance	100%	$5,000
Diagnostic laboratory and x-ray procedures	100%	Unlimited
MRI	100%	$750 per calendar year
Dental care as the result of an accident	100%	$5,000
Second medical opinion		**Included**

LIFETIME MAXIMUM FOR Part I and II	**$50,000**

SAMPLE

HOMECARE ASSISTANCE
PLAN 2
Benefits schedule

Protection	Coinsurance	Annual Maximum
Part I	**Payable when the insured person is functionally dependent**	
Specialists		
Audiologist	100%	$1,500 per calendar year
Dietitian	100%	$1,500 per calendar year
Naturopath or osteopath	100%	$1,500 per calendar year
Occupational therapist	100%	$1,500 per calendar year
Physiotherapist	100%	$1,500 per calendar year
Podiadrist or chiropodist	100%	$1,500 per calendar year
Respiratory therapist	100%	$1,500 per calendar year
Speech therapist	100%	$1,500 per calendar year
Other expenses Covered at 100 %		
Monitoring system	100%	$1,000 per calendar year
Moving allowance	100%	$1,000 lifetime maximum
Home conversion	100%	$15,000 lifetime maximum
Meals	100%	$700 per month
Purchase or rental of equipment	100%	Unlimited
Respite	100%	$3,000 per calendar year
Transportation expenses	100%	$750 per year
Informal caregiver support	100%	$1,500 per year
Private nurse or personnal support worker	100%	$75 per day, maximum of 200 days per calendar year

SAMPLE

Other expenses

Covered at 100 %

Orthopaedic shoes	100%	Unlimited
External breast prostheses following a mastectomy	100%	$300 per 24 months
Supplies for colostomy, an ileostomy, or a urostomy.	100%	Unlimited
Tens	100%	$500 per 36 months
Purchase of reagent strips, syringes, and needles. Accessories for diabetics, dextrometer or a glucometer.	100%	Unlimited
Hearing aids	100%	$500 per 36 months
Wigs (required for pathological conditions or following chemotherapy treatments)	100%	$300 lifetime maximum
Stockings for varicose veins and phlebitis	100%	2 pairs per calendar year
Maxi-mist machine, including the masks, or a CPAP machine	100%	$500 lifetime maximum
Rental, purchase or repair of non-motorized wheelchair, hospital bed (excluding mattress), ventilator and crutches	100%	$7,500 lifetime maximum
Medical supplies	100%	$1,500 per year
Incontinence supplies-bowel and /or bladder	100%	$1,500 per year

Part II — Payable in case of accident or sickness

Hospitalization and ambulance

Hospitalization	100%	Semi private room 200$ per day 180 days lifetime maximum. If no semi-private room available, $50 per day of hospitalization, from the second day of hospitalization
Convalescent hospital	100%	Semi private room $60 per day, Maximum of 120 days
Ambulance	100%	Unlimited
Air ambulance	100%	$5,000
Diagnostic laboratory and x-ray procedures	100%	Unlimited
MRI	100%	$750 per calendar year
Dental care as the result of an accident	100%	$5,000
Second medical opinion		**Included**

LIFETIME MAXIMUM FOR Part I and II	**$100,000**

SAMPLE

HOME CARE ASSISTANCE

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SAMPLE

GENERAL PROVISIONS/STATUTORY CONDITIONS

The use of masculine nouns and pronouns in this contract is assumed to include the feminine equivalents. The same is true of the singular and plural.

CONTRACT

The contract is comprised of the policy and any rider, amendment and copy of any application attached to the policy. If the contract lapses and is subsequently reinstated, the written notice of reinstatement becomes an integral part of the contract.

The general provisions of this contract apply to all coverage under this contract insofar as these provisions are not incompatible with the terms of each of the benefits.

DEFINITIONS

In this policy, unless otherwise specified:

Accident means a sudden, fortuitous and unforeseeable event that causes, directly and independently of all other causes, bodily injuries resulting exclusively from an external cause that is of a violent nature and unintended by the Insured.

Activities of daily living definition:

(a) **Bathing** means washing with or without the aid of assistive devices in a bathtub or shower, including getting in and out of the bathtub or shower, or by sponge bath.
Bathing doesn't include the ability to reach and wash the back or feet.

(b) **Dressing** means putting on, taking off, fastening and unfastening, with or without the aid of assistive devices: clothing, and medically necessary braces or artificial limbs. An Insured is not functionally dependent for dressing if reasonable alterations to or changes in the clothing the Insured usually wears would let the Insured dress himself or herself without substantial physical assistance.

(c) **Toileting** means getting to and from and on and off the toilet, with or without the aid of assistive devices, and performing associated personal hygiene.

(d) **Transferring** means moving into or out of a bed, chair or wheelchair, with or without the aid of assistive devices.

(e) **Feeding** means consuming food or drink that has been prepared and served, with or without the use assistive utensils.

(f) **Continence** means the ability to control either bladder or bowel functions, or maintain a reasonable level of personal hygiene (including caring for catheter or colostomy bag) when not able to control bowel or bladder functions.

Age means the age of the Insured on his last birthday at the date of issue of the policy or rider with regard to the Insured, as applicable, as indicated in the Policy Specifications.

Amount due means any premium due and unpaid on the contract.

Application means any insurance application attached to the policy.

Benefit Schedule means the Benefit Schedule attached to this policy.

Date of issue means the date of issue of the policy or rider, as applicable, as indicated in the Policy Specifications.

SAMPLE

Functionally dependent means that the Insured is unable to accomplish two or more activities of daily living or has a deteriorated mental ability or needs stand-by assistance to perform bathing or transferring. To be considered functionally dependent, the Insured must also, if applicable, follow recommended treatments made by a health care professional.

Deteriorated mental ability (cognitive impairment) means that continuous supervision by another person is needed for protection from threats to physical health and safety as the result of deterioration in or loss of:

- Short-term memory;
- Orientation as it relates to people, place and time;
- Reasoning or
- Judgment as it relates to safety or awareness.

Deteriorated mental ability must result from an organic brain disorder such as Alzheimer's disease, irreversible dementia, or brain injury. Diagnosis must be made by physician.

Facility means a long-term care centre offering residential, assistance, support, supervisory and psychological services for Insured suffering a loss of functional or psychological autonomy.

Head office means P.O. Box 696, Drummondville, Quebec, J2B 6W9

Home Care means health and personal care services received outside a facility. Home care means the Insured is functionally dependent and residing in a private residence or a location that does not meet the definition of facility in this contract.

Hospitalization means an admission to a hospital:

(a) as an in-patient for a period of at least 18 hours for emergency medical treatment; or
(b) for surgery that is not mainly of a cosmetic nature.

Hospital means a short-term care hospital, recognized as such by law that dispenses care and treatment to ill or injured people and provides diagnostic procedures, surgical services and continuous nursing services. For purposes of this definition, hospitals and facilities do not include homes for the elderly, convalescent homes, medical clinics or centres specialized in treating alcoholism and/or drug dependency or any other type of dependency.

Illness means the deterioration in health or a physical disorder diagnosed by a physician. Pregnancy is not considered an illness, except in the event of pathological complications.

Injury means bodily harm or damage caused by an accident, directly and independently of any other cause.

Insurability means the condition of an Insured who meets the Insurer's eligibility and state of health requirements for enrolment.

Insured means the insured person as indicated in the Policy Specifications.

Insurer means UV Insurance.

Policy means this policy, excluding any rider and insurance application.

Policy anniversary means the anniversary of the date of issue of the policy. Policy years are calculated from the date of issue of the policy.

SAMPLE

Owner means the person who purchases the insurance as indicated on the application.

Policy Specifications means the information pertaining to the policy and to any rider, if applicable, indicated in the pages titled “POLICY SPECIFICATIONS”.

Physician means an individual who holds a valid license from the College of Physicians and Surgeons from the province or territory within which he is practicing in Canada or a valid license in the United States to practice medicine and treat illnesses and injuries, and who practices under the terms of that license. Physician does not include the Insured, or a person who is a member of the Insured’s immediate family, nor an individual who holds any other health-related license or degree.

Rider means any document identified as “rider” that provides for additional benefits applied for by the Insured and that is issued and approved by us and is an integral part of the policy only when indicated in the Policy Specifications.

You and **your** refer to the Insured under this contract.

We, **us** and **our** refer to the Insurer under this contract.

AMENDMENT

The Insurer will not be bound by any agreement, promise, application, representation or understanding that is not expressly contained in the contract. Only the Insurer’s president and chief executive officer is authorized to amend the contract and its terms and conditions, and then only in writing. No broker, agent or other representative is authorized to modify any of the provisions of the contract.

METHOD OF PREMIUM PAYMENT

Premiums are payable at our head office or to an authorized representative on an annual or monthly basis, subject to our administrative rules. The first premium is due on the date of issue. Each subsequent premium is due at the end of the period covered by the previous premium.

You may, at any time, request that the method of premium payment indicated in the Policy Specifications be changed, subject to our administrative rules.

CURRENCY AND PLACE OF PAYMENT

Amounts to be paid by or to the Insurer will be in Canadian dollars. Premiums payable under the contract must be remitted to our head office or to one of our authorized representative

CONTRACT`S PREMIUM

The annual premiums of the policy and any rider are specified in the Policy Specifications. They are established based on the benefit selected, the sex, and the attained age of the Insured when the application is signed.

On a yearly basis, the Insurer reserves the right to modify the unit rates as long as the unit rates for identical contracts are modified.

PREMIUM PAYMENT PERIOD

Premiums of the policy and any rider, if applicable are payable until the dates indicated in the Policy Specifications.

INSURED GRACE PERIOD

SAMPLE

Except for the payment of the first premium, a grace period of thirty-one (31) days is granted for premium payment. The contract remains in force during this grace period, subject to any other cause of termination or cancellation, but no benefit is payable as long as a premium remains unpaid.

LAPSE

The contract lapses and the insurer`s obligations hereunder cease automatically if premiums remain unpaid after the grace period.

EFFECTIVE DATE OF POLICY

The policy takes effect on the date the application is approved by the Insurer provided that:

(1) It has been approved without amendment;

(2) The first policy premium has been paid; and

(3) Any information or answer provided in the application remains complete and true on the date the application is approved by the insurer or on the date of issue of the policy, if later.

If the policy is approved with amendments, it will take effect on the date it is delivered to the Insured, provided that any Insured's health status remains unchanged.

REINSTATEMENT

The policy and any attached rider may be reinstated upon fulfillment of **all** of the following conditions:

(1) The Insured requests reinstatement in writing to the Insurer within one hundred and twenty (120) days following their lapse;

(2) Satisfactory proof of insurability is provided to the Insurer by the Insured;

(3) The Insured pays all outstanding premiums;

(4) We have not received written notice requesting termination of the policy or rider.

The reinstatement will not extend the duration of the contract or the expiry date of the policy or any rider beyond the expiry dates indicated in the Policy Specifications.

ASSIGNMENT OR PLEDGE

Insurance under this contract may not be assigned or pledged.

CANCELLATION BY THE OWNER

The Insured may cancel his contract by sending a written notice to the Insurer's head office. If the premium was paid on an annual basis, the cancellation date will be the date the notice is received. However, if the premium is paid monthly, notice must be received 7 business days before the next automatic withdrawal before cancellation becomes effective. Otherwise, the withdrawal will be made and there will be no reimbursement of premiums, and cancellation will take effect at the end of the period for which the premium was paid.

TERMINATION BY THE INSURER

SAMPLE

As long as the Insured pays the premiums, the Insurer cannot terminate a contract before the Insured reaches the maximum age.

INCONTESTABILITY

Except in the case of fraud, we will not contest the policy for misrepresentation or failure to inform us of all material facts in connection with the insurance after the policy has been in force during the Insured's lifetime for a period of two years from the later of the following dates:

(a) The date of issue of the policy;

(b) The last date of reinstatement.

Any misrepresentation or failure to inform us of all material facts in connection with the insurance may render the policy voidable at our option within two years from the later of the above dates. Fraud will automatically render the policy void and the responsibility of the insurer will be limited to the reimbursement of the premiums for the last 24 months minus the claims paid. No benefit will be payable in either case and the Insured must reimburse any benefits received.

MISSTATEMENT OF AGE OR SEX

If the age or sex of the Insured under the policy has been misstated, the premium amounts shall be adjusted retroactively to the date of issue of the policy to reflect the correct age and sex of the Insured. All amounts owed by the owner of the policy constitutes a debt for which the insurer is entitled to deduct, at its own discretion, up to 100% of future benefits payable under the policy. If on the date of issue of the policy the age of the Insured was outside the applicable age limits, the policy will be deemed void, subject to any legal restrictions.

NOTICE AND CORRESPONDENCE

Any notice or correspondence to be delivered will be sent to the Insured last known mailing address or to the last known e-mail address that you have provided. Any postal or e-mail communication sent to you will be deemed received 7 days after it has been sent.

Any notice that the Insured must give the Insurer may be delivered by mail, messenger, fax or any form of electronic transmission. Certain restrictions apply when sending any form that needs to be signed by the Insured. All communication with the Insurer will be deemed received on the date of receipt at our head office.

NOTICE AND PROOF OF CLAIM

In the event of a claim, the Insured must remit to the Insurer all information and supporting documentation that the Insurer reasonably may expect concerning the circumstances and extent of the claim. Failure to provide all the necessary information could result in delays in processing the claim or denial of the claim.

ACCESS TO PERSONAL INFORMATION

Any claim under the terms of the policy or of any rider, as applicable, must be submitted in writing and supported by the relevant documents. We reserve the right to request any information that we deem relevant in support of said claim.

At the time of processing a claim, personal information concerning the Insured, including medical information on the Insured's state of health, will be required.

SAMPLE

No amount will be paid in the event that the Insured or the Insured's estate, legal guardian or personal representative refuses to consent to the disclosure of personal information pertaining to the Insured that we deem necessary for claim processing purposes.

RIGHT TO CANCEL POLICY AT NO CHARGE

The Insured has 10 days following receipt of the contract to review it and cancel it, without incurring any fees or penalty, provided that we receive a written notice to that effect at our head office within the time specified.

Upon receipt of the cancellation notice within the time specified, we will reimburse the full amount of premiums paid. The contract will be considered null and void as of the date of issue, and no benefit will be payable.

ELIGIBILITY

To be eligible to apply for this coverage, the Insured must be eligible to receive benefits from the government hospitalization plans and provincial health care programs of his province of residence. The Insured must be between 18 and 80 years of age inclusively.

TERMINATION OF INSURANCE

The insurance of an Insured terminates automatically upon the earliest of the following dates:

(a) The date of termination of this contract;

(b) The last day of the grace period if the premium remain unpaid

(c) The date that the Insurer receives written notice from the owner to this effect or on any later date mentioned in said notice;

(d) The date that the Insured makes false representations to the Insurer or the date that he or she commits a fraudulent act that affects the Insurer;

(e) The date of death of the Insured;

(f) The date the lifetime maximum is reached.

RENEWAL

Provided that no premium is outstanding on the last day of an insurance year, this contract is automatically renewed each year.

The years of insurance each have a 12-month period and are calculated from the effective date of the contract.

COLLECTION

No provision in this contract may be interpreted as preventing the Insurer from recovering any amount that has been overpaid.

WAIVER

The Insurer's waiving or omitting to require any provision in the contract to be executed or observed must not be interpreted as the Insurer's waiver of its right to take the necessary measures against any subsequent failure to execute or observe same

SAMPLE

provision. Moreover, approval by the Insurer of any act on the part of the Insured when this approval was required does not relieve the Insured from having to obtain the Insurer's approval for any subsequent similar act.

SUBROGATION AND REIMBURSEMENT – THIRD PARTY LIABILITY

When any amount is paid out to a person under this contract subsequent to an accident or illness for which a third party is legally liable, the Insurer is subrogated in the rights of the Insured and may recover from the liable third party the amounts paid out to the extent permissible by law.

SAMPLE

HOME CARE ASSISTANCE

DEFINITIONS

For purposes of this coverage:

Assistive devices means aids that could be used to improve your functioning. If using an assistive device allows you to perform an activity of daily living safely and completely, you're not functionally dependent for that activity.

Assistive devices include but are not limited to: adjustable beds, buttonhooks, canes, crutches, grab bars, handheld showerheads, bath brushes, seat lifts, transfer benches, walkers and wheelchairs.

Coinsurance means the percentage of eligible expenses reimbursed by the Insurer to the Insured for certain types of health and/or dental care.

Co-payment is the amount of eligible expenses payable by the Insured for each claim.

Consultation takes place when the Insured is referred by a health professional for an appointment with another health professional who can make recommendations or provide an opinion because he or she has expertise that is pertinent to the case.

Convalescent hospital means any institution intended for the care of the sick who are in a transitional period between the end of the period of active affection and the full recovery of health. To be considered a convalescent hospital, this institution must meet all of the following conditions:

(a) Be eligible to receive payments in accordance with the provisions of the provincial law on medical care;

(b) Be managed in accordance with the applicable laws of the jurisdiction in which it is located;

(c) Have a certified physician and registered nursing staff providing service 24 hours a day;

(d) Provide room and board and nursing care during the convalescent period following the illness or injury;

(e) Be authorized to administer medication to patients according to the instructions or recommendations of a physician;

(f) Keep a medical file on each patient;

(g) Not be a retirement home, a nursing home, a maternity home, or an institution for the blind, deaf, alcoholic, drug addict, or mentally handicapped.

Diagnostic services refer to the medical examinations and tests necessary to identify the type or extent of an illness or an injury that are administered to the Insured in the office of a physician or dentist, in a hospital, or in a private health care institution previously approved by the Insurer, when these examinations and tests have been prescribed by a physician, a dentist or a nurse practitioner.

SAMPLE

Eligible expenses are those costs incurred by the Insured for medical supplies or services that are considered to be refundable because they:

(a) Are reasonable, usual, and customary expenses;
(b) Have been recommended, approved, or prescribed by a health professional;
(c) Have been approved by the Insurer;
(d) Exceed the amounts refunded or refundable by another Insurer or government plan;
(e) Have not been provided by a person who lived with the Insured prior to the Insured being functionally dependent or who is part of his or her immediate family, who is his or her business partner or who is his or her employer
(f) Were incurred while this coverage was in force.

Government plan means any insurance plan established by or under the administrative control of any level of government or any government agency.

Health professional means any person who is legally licensed to practice a profession that involves the administration of medical services. Health professionals include physicians, pharmacists, dentists, nurse practitioners and any other professional approved by the Insurer.

Immediate family refers to the spouse, child, brother, sister, parent, grandparent or grandchild of the Insured.

Informal caregiver means a nonprofessional person who provides care and/or support to a family member, friend, neighbour who is functionally dependent.

Lifetime maximum means the overall maximum applicable per Insured for Part I and II combined as indicated in the Benefit Schedule.

Maximum amount of coverage means the amount of coverage available for a specified period for each Insured as indicated in the Benefit Schedule, without taking into account any coinsurance.

Private nurse means any registered nurse or a licensed practical nurse who is a member in good standing of his or her respective professional association.

Personal support worker means any certified personal support worker who is a member in good standing of his or her respective professional association.

Reasonable, usual, and customary expenses are fees or charges that do not exceed the amounts generally charged by other professionals, similar health care establishments, or pharmacies in the same jurisdiction for identical or comparable care, services, or supplies. These amounts are set annually or more often by the Insurer.

Stand-by assistance means another person must always be within arm's reach so you can safely and completely perform the activities of bathing and transferring. If you require stand-by assistance for only one of bathing or transferring, you are considered functionally dependent when you also require substantial physical assistance to perform one of the other activities of daily living.

SAMPLE

SCOPE – HOME CARE ASSISTANCE

Provided that this coverage is in force on the day an Insured is considered functionally dependant and incurs expenses for Part 1 or incurs expenses following an illness or accident for Part 2, the Insurer shall reimburse, in accordance with the settlement terms indicated in the Benefit Schedule and all other provisions of the contract, the eligible expenses described below.

CONDITIONS AND ELIGIBILITY

This coverage provides for the reimbursement of expenses incurred for the services, supplies, and medical care described in the "Eligible expenses" section, subject to the applicable limitations and exceptions.

This coverage is not intended to replace the health insurance plan of the province in which the Insured resides or any other government health insurance plan.

To be eligible for this benefit, the Insured must be between 18 years of age and 80 years of age inclusively at signing of application. The maximums indicated for this benefit are per Insured and are specified in the Benefit Schedule.

ELIGIBLE EXPENSES

PART I - EXPENSES FOR THE FUNCTIONALLY DEPENDENT INSURED

Provided that this coverage is in force on the day the functionally dependent Insured (who is not residing permanently or temporarily in a facility), incurs expenses, the Insurer will pay based on the percentage and maximums indicated for this purpose in the Benefit Schedule, the following reasonable, usual and customary expenses:

SPECIALIST SERVICES

The expenses for **paramedical services** provided by a/an:

Audiologist	Physiotherapist
Dietitian	Podiatrist or chiropodist
Naturopath or osteopath	Respiratory therapist
Occupational therapist	Speech therapist

provided that these services are in their field of specialty and these professionals are members of their professional associations, subject to the coinsurance, and up to the maximum for that specialist as indicated in the Benefit Schedule.

The provider cannot reside in the home of the Insured, be part of his or her immediate family, be his or her business partner or be his or her employer. These expenses are reimbursable up to the maximum amount indicated in the Benefit Schedule.

SAMPLE

OTHER EXPENSES

The Insurer pays, based on the percentage and maximums indicated for this purpose in the Benefit Schedule, the following reasonable, usual, and customary fees for:

Monitoring system

Cost of a medical alarm system which consists of an emergency wireless transmitter, with a base station, which is connected to the telephone and contains a very sensitive microphone and loud speaker, up to the maximum indicated in the Benefit Schedule.

Moving allowance

Cost for relocation expenses that the Insurer will pay the Insured to move from his residence to a long-term care facility, up to the maximum indicated in the Benefit Schedule.

Home conversion

Cost for the adaptation of the Insured's home up to the maximum indicated on the Benefit Schedule.

Meals

Cost for preparing meals cooked outside the residence of the Insured, up to the maximum indicated on the Benefit Schedule.

Purchase or rental of equipment

The rental or purchase, at the Insurer's discretion, of the following medical supplies or equipment:

- Walkers or other mobility aids: canes, crutches, walking frames;
- Orthopaedic devices made from rigid materials, such as plastic or metal, that help to keep a part of the body properly positioned. (elastic support bandages and foot orthoses are not covered in this category);
- The cost of oxygen, or a ventilator as well as the rental of the equipment necessary to administer it.

Respite

Cost for respite care for the Insured to allow the informal care giver respite and time off, up to the maximum indicated in the Benefit Schedule.

Transportation expenses

Cost for transportation of the Insured to receive care or medical follow-up. If the Insured is transported by a private car, the allowance is $0.35/km or the cost of a taxi, up to a maximum of $50 per day and up to the maximum indicated in the Benefit Schedule.

Informal caregiver support

Cost for the consultation of a specialist that provides psychosocial support to the informal caregiver in his daily duty and involvement with the Insured up to the maximum indicated in the Benefit Schedule.

SAMPLE

Private nurse or personal support worker

The professional services of a registered private nurse, or a personal support worker from an agency specializing in home care, who is a member in good standing of his or her respective professional association, up to the maximum amount indicated in the Benefit Schedule.

Orthopaedic shoes

The purchase of orthopaedic shoes up to the maximum indicated in the Benefit Schedule.

External breast prosthesis

The purchase of external breast prostheses following a mastectomy, up to the maximum indicated in the Benefit Schedule.

Supplies for a colostomy, an ileostomy, or a urostomy

The cost of eligible supplies that becomes necessary after a colostomy, an ileostomy, or a urostomy, up to the maximum indicated in the Benefit Schedule.

TENS

Transcutaneous electrical nerve stimulator for control of chronic pain, up to the maximum indicated in the Benefit Schedule.

Reagent strips, syringes and needles

The purchase of **reagent strips, syringes and needles,** up to the maximum indicated in the Benefit Schedule.

Dextrometer or a glucometer and diabetic supplies

The purchase of a **dextrometer or a glucometer for diabetics: diabetic supplies,** up to the maximum indicated on the Benefit Schedule. The following diabetic supplies:

- Bloodletting devices, including platforms but not lancets;
- Insulin infusion sets, not including infusion pumps.

Glucose sensors are not covered.

Hearing aid

The purchase of a hearing aid, prescribed by an audiologist, up to the maximum amount indicated in the Benefit Schedule for a period of 36 consecutive months.

Wigs

Wigs (required for pathological conditions or following chemotherapy treatments), up to the lifetime maximum amount indicated in the Benefit Schedule.

Stockings for varicose veins and phlebitis

Stockings for varicose veins and phlebitis, up to the maximum amount indicated in the Benefit Schedule.

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Maxi-mist machine, including the masks, or a CPAP machine

The rental or purchase, at the Insurer's discretion, of a maxi-mist machine, including the masks, or a CPAP machine, up to the maximum amount indicated in the Benefit Schedule.

Rental or purchase of a non-motorized wheelchair, hospital bed (excluding mattress), ventilator and crutches

Rental or, at the Insurer's discretion, purchase of a non-motorized wheelchair (including repairs), a hospital bed (excluding mattress), or any other equipment normally considered to be used in a hospital for the purpose of treatment, up to the maximum amount indicated in the Benefit Schedule.

Medical supplies

The purchase, at the Insurer's discretion, of medical supplies to treat an illness or an accident when an Insured receives care from a nurse, up to the maximum amount indicated in the Benefit Schedule.

Incontinence supplies-bowel and/or bladder

The cost for incontinence supplies-bowel and/or bladder, up to the maximum amount indicated in the Benefit Schedule.

PART II (EXPENSES FOLLOWING AN ACCIDENT OR AN ILLNESS)

Provided that this coverage is in force on the day an Insured incurs expenses following **an illness or accident,** the Insurer shall reimburse, in accordance with the settlement terms indicated in the Benefit Schedule and all other provisions of the contract, the eligible expenses described below.

HOSPITALIZATION

Hospitalization expenses in Canada

The Insurer pays hospitalization expenses in Canada in excess of those payable under any government insurance plan, up to the cost of a semi-private room as indicated in the Benefit Schedule. If no semi-private room is available at time of hospitalization, the Insurer will pay $50 per day of hospitalization, from the second day of hospitalization.

The term hospitalization excludes any stay in a retirement home, a nursing home, a maternity home, or an institution for the blind, deaf, alcoholic, drug addict or mentally handicapped.

Convalescent Hospital

Expenses for room and board and other necessary services in a convalescent hospital that are in excess of the charges for a ward, up to a maximum indicated in the benefit schedule per day for up to a maximum of 120 days, will be considered eligible expenses under all of the following conditions:

(a) The Insured is admitted to the convalescent hospital within 14 days following hospitalization;

(b) This hospitalization lasted at least two consecutive days; and

(c) The stay in the convalescent hospital was prescribed by the Insured's attending physician.

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(d) All stays in a convalescent hospital will be considered one and the same stay unless these stays are separated by at least 90 days. To be eligible for reimbursement of convalescent hospital expenses, the convalescent hospital must be approved by the **appropriate provincial housing authority**. Expenses for particular types of care or for chronic illnesses in a convalescent hospital, a nursing home, or a similar institution will not be considered eligible expenses.

Ambulance and air ambulance

When required but not covered by a government plan, the expenses for transportation by ambulance to or from the nearest hospital that delivers the appropriate level of care, as well as air transport when the Insured cannot be transported by any other means, up to the amount indicated in the Benefit Schedule per Insured per 12 consecutive months.

Diagnostic laboratory and X-ray procedures

Diagnostic laboratory and X-ray procedures, up to the amount indicated in the Benefit Schedule per period of 12 consecutive months performed in the Insured's province of residence.

Magnetic resonance imaging (MRI)

Magnetic resonance imaging (MRI) expenses, up to the maximum indicated in the Benefit Schedule per calendar year.

Dental care as a result of an accident

Subject to prior evaluation by the Insurer, expenses for professional services rendered by a dental surgeon to repair damage caused to natural teeth in an accident that occurred while the Insured was covered under this benefit; these services must be rendered during the six months following the date of the accident, and this coverage must be in effect at the time this care is provided.

Eligible expenses will be reimbursed up to a $5,000 maximum of the fees set forth in the Fee Schedule for that year for the use of the general practitioner and approved by the College of Dental Surgeons, and the fees set forth in the Fee Schedule approved by the College of Denturists. These colleges are those of the province in which the Insured resides.

COORDINATION OF BENEFITS

Expenses are only paid in excess of those payable under another insurance plan. When expenses are added to any other benefits provided through other insurance plans covering these same insurable expenses, the overall benefits do not exceed the true amount of expenses incurred.

WAIVER OF PREMIUMS

When the Insurer approves a claim for benefits under PART I, the Insurer will waive the premiums for the policy as long as the Insured is functionally dependent. Premiums must be paid until the Insurer gives notice that the claim is approved.

EXCLUSIONS

No benefits are payable under these coverages for expenses incurred following:

(a) Self-inflicted injuries or physical or mental damage;

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(b) The commission of or an attempt by the Insured to commit a criminal act;

(c) Injuries sustained by the Insured during active participation in a civil commotion, a riot, an insurrection, or a military action, whether war has been declared or not;

(d) Alcohol or drug abuse, or use of illegal drugs;

(e) Driving a motor vehicle when the Insured blood alcohol level exceeds 80 milligrams of alcohol per 100 milliliters of blood, or exceeds the legal limit permitted by law;

(f) Inhalation by the Insured of toxic gases, unless this inhalation occurs in the ordinary course of the Insured's employment;

(g) Suicide or attempted suicide by the Insured, whether or not the Insured was of sound mind at the time.

No benefits are payable for a functionally dependent Insured who resides outside Canada or the United States.

No benefits are payable when the Insured resides in a facility.

NOTICE AND PROOF OF CLAIM

In the event of a request for payment, the Insured must present his or her claim to the Insurer, while coverage is in force, accompanied by all the supporting documentation considered necessary by the Insurer, within 12 months following the date that the expenses were incurred; otherwise, the claim will not be accepted.

Eligible expenses are reimbursed or paid out within 30 days after receipt of the claim accompanied by all the necessary supporting documentation.

The Insured who disagrees with a decision of the Insurer may request a review within the 30 days following this decision by sending a written request to the Insurer and adding any new supporting documentation.

No request for a review will be considered if it is received more than 12 months after the Insurer's original decision.

Claim payments after your policy ends

We must receive your claim within 90 days of the date your policy ended. We will not pay for any claims received by us after 90 days, regardless of when the expense was incurred.

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EXPERT MEDICAL OPINION

Any Insured covered under this insurance benefit is entitled access to a second medical opinion benefit. The current provider of this benefit is Best Doctors; however, the provider and the services offered are subject to change at UV Insurance's discretion

Best Doctors

Coverage begins on the effective date of this policy, provided that the Insured meets the eligibility criteria and that Best Doctors services are available.

Best Doctors helps you make medical decisions with confidence. They provide access to the best medical minds in the world so you can feel empowered with the right information about your diagnosis and treatment plan. They also help you find specialists and get expert answers to medical questions. Whether you're dealing with a chronic condition, questioning surgery or facing a life-threatening illness, Best Doctors can guide you in the right direction.

You have unlimited access to the following Best Doctors services:

Expert Medical Opinion*

When a second opinion is required regarding a medical diagnosis or treatment plan, Best Doctors experts will conduct an in-depth analysis of your medical records, including imaging scans, X-rays, test results and any available pathology (which can be retested). You will receive a written report of their findings, which includes a diagnosis and treatment recommendations that you can share with your doctor.

FindBestDoc*†

If you're searching for a local specialist let Best Doctors do the work for you. They will search their database of top Canadian specialists and take into account your unique medical history and geographic location, matching you with the right physician for your condition.

FindBestCare*†

If you need a specialist outside of Canada* they can make it possible through their FindBestCare service. They will cater the search to your unique medical history and geographic location, as well as availability of the specialist and/or facility.

Best Doctors 360°®*

Best Doctors 360° can help you navigate the Canadian healthcare system and get you the information you need for a variety of health topics. Best Doctors provides you with a variety of tools and resources when you're facing medical uncertainty, and can offer advice and wellness support if you need it. You'll gain peace of mind knowing you're making an informed decision about your health care.

* Individuals are responsible for any expenses associated with medical treatment, travel and lodging.
† Best Doctors does not make referrals or appointments for members.

Get started today

Go online at bestdoctors.com/canada/start or call 1-877-419-2378. You need to identify yourself by providing your

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insurance policy number. When you contact Best Doctors, you will be assigned a Member Advocate who will assess your medical issue, answer your questions, determine what service would best meet your needs and keep you informed about the progress of your case.

About Best Doctors

Founded in 1989 by Harvard Medical School physicians, Best Doctors is a benefit that provides access to the best medical minds in the world so you can feel empowered with the right information. It is designed to complement the care you receive from your own physician.

Best Doctors uses the top 5% of medical experts in the world to provide you with the right advice at the right time so you can make informed medical decisions with confidence.

Best Doctors is now part of Teladoc Health, the global leader in virtual care.

Best Doctors and the star-in-cross logo are trademarks of Teladoc Health, Inc., in the United States and in other countries, and are used under license.

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